



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-04077-405

Healthcare Inspection

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

July 7, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

Web site: www.va.gov/oig

Table of Contents

Executive Summary	i
Purpose.....	1
Background.....	1
Scope and Methodology	2
Inspection Results	4
Issue 1: Mat-Su VA CBOC Provider Staffing and Workload	4
Issue 2: Access to Care and Quality of Care Concerns at the Mat-Su VA CBOC	6
Issue 3: Mat-Su VA CBOC Security	17
Issue 4: System Failure to Maintain Appropriate Scheduling Practices in 2008.....	17
Issue 5: Failure To Ensure Adequate Urology Care Following the Departure of the System’s Only Urologist in 2008	18
Issue 6: Other Findings	20
Conclusions.....	24
Recommendations.....	25

Appendixes

A. Provider Staffing at Mat-Su VA CBOC	27
B. VISN Director Comments	28
C. System Director Comments	29
D. OIG Contact and Staff Acknowledgments.....	34
E. Report Distribution.....	35

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the request of Senator Lisa Murkowski to assess the merit of allegations regarding (1) provider availability, workload, access, quality of care, and security at the Mat-Su VA Community Based Outpatient Clinic (CBOC), Wasilla, AK, and (2) scheduling practices at the Alaska VA Healthcare System (system), Anchorage, AK.

We substantiated the allegation that provider workload and staffing negatively impacted access to care at the Mat-Su VA CBOC for the patients reviewed. We further substantiated that the Mat-Su VA CBOC lacked a permanent provider from May to October 2014.

We substantiated that decreased and delayed access resulted in quality of care issues. Patient care was compromised by a lack of communication, care coordination, and follow-up, in addition to outright delays in the provision of care.

We did not substantiate the allegation that since its opening, the Mat-Su VA CBOC has been plagued by security issues.

We substantiated the allegation that the facility did not comply with Veterans Health Administration (VHA) scheduling directives in 2008. However, we did not find evidence of current scheduling irregularities.

We substantiated the allegation that adequate urology services were not available to patients following the departure of the system's only urologist in 2008.

In addition, we found organizational structure and processes lacking, particularly in areas under the domain of clinical leadership. Insufficient processes in peer review, provider evaluation, and committee activity and reporting, as well as issues of culture and employee morale, have the potential to compromise patient safety.

We recommended that the Veterans Integrated Service Network Director ensure that the System Director:

- Implement an action plan based on ongoing monitoring of access performance measures that includes recruitment and retention, and ensure continued provision of primary care by a permanent provider at the Mat-Su VA CBOC.
- Implement contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events, as required by VHA policy.
- Implement the requirements of VHA Handbook 1101.10, *Patient-Aligned Care Teams*, regarding care coordination.
- Provide access to care at the Mat-Su VA CBOC in accordance with VHA policy and provider recommendations for follow-up.

- Perform peer review and consult regional counsel as appropriate for the cases identified in this report.
- Implement peer review and a provider evaluation process consistent with VHA policy.
- Strengthen processes for committee reporting to align with VHA Directive 1026, *Enterprise Framework for Quality, Safety, and Value* and system Bylaws.
- Assess the culture, morale, and leadership issues identified in this report, and take appropriate action as necessary.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes B and C, pages 28–33 for 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 Inspection

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Lisa Murkowski to assess the merit of allegations regarding (1) provider availability, workload, access, quality of care, and security at the Mat-Su VA Community Based Outpatient Clinic, Wasilla, AK, and (2) scheduling practices at the Alaska VA Healthcare System (system), Anchorage, AK.

Background

System Profile. The system serves veterans throughout the state of Alaska and is part of Veterans Integrated Service Network (VISN) 20. Primary, specialty, and mental health outpatient care is provided by the parent outpatient clinic located in Anchorage; at community based outpatient clinics (CBOCs) in Fairbanks, Kenai, and Wasilla; and an Outreach Clinic in Juneau. Inpatient services are provided through fee basis arrangements¹ with community hospitals and a joint venture (JV) with Department of Defense Joint Base Elmendorf-Richardson, located adjacent to the parent outpatient clinic in Anchorage.

Alaska has a chronic shortage of physician providers, ranking 17th lowest in the nation in its physician-to-population ratio, with 2.05 doctors per thousand residents compared to the national average of 2.38 per thousand. It is one of six states without an independent in-state medical school. Instead, it funds 20 state-supported “seats” at the University of Washington’s medical school. By 2025, some estimates are that Alaska will need nearly twice as many physicians as practiced in the state in 2004 (about 1,347).²

OIG has published two reports related to access to care in Alaska. In 2005, the OIG published, *Surgical Service Issues, Alaska VA Healthcare System and Regional Office* (Report No. 05-02527-205, September 20, 2005), which examined timely access to VA patients’ surgical needs. OIG found that VA patients’ surgical needs were not being met by the JV hospital arrangement with Joint Base Elmendorf-Richardson, particularly for patients awaiting orthopedic surgery. The report also substantiated lack of compliance with Veterans Health Administration (VHA) directives and The Joint Commission (JC) standards requiring the Chief of Surgical Services to be a physician (this position was being filled by a Physician Assistant). The OIG received documentation that the facility had implemented recommendations from this report and closed those recommendations on November 29, 2005.

In 2010, the OIG conducted a review of patient referrals and transfers from the VA system in Anchorage to VA specialty care providers outside of Alaska, *Review of*

¹ “Fee-based care” is a term that refers to purchasing health care outside the VA system. This term has been replaced by non-VA medical care or purchased care. When this care is obtained through a provider placing a consult, it is called a Non-VA Care Consult.

² *Adequate Number of Physicians for Alaska’s Needs: Report of the Alaska Physician Supply Task Force*, April 2006.

Patient Referrals to Lower 48 States at the Alaska VA Healthcare System, Anchorage, AK (Report No. 10-01509-241, September 9, 2010). The vast majority (96 percent) of patients were able to receive health care directly through the system or indirectly through Department of Defense JV agreements and community contracted and fee-based services in Alaska. Approximately four percent of patients received specialty care outside of Alaska, primarily for orthopedic, neurosurgery, neurology, oncology, and cardiology specialty care services. The OIG made no recommendations.

In May 2014, at the request of the Secretary of the Department, VHA conducted a system-wide audit of scheduling and access management practices; this audit included the system in Anchorage. Of the 216 sites visited in VHA's Phase One Access Audit, 81 (37 percent) were identified as needing further review; the system was not one of the sites identified as needing further review. As of May 15, 2014, the system reported scheduling 91 percent of appointments in 30 days or less. As of December 5, 2014, the system was able to schedule 99 percent of appointments in 30 days or less.

Allegations. OIG received a letter from Senator Lisa Murkowski, requesting that we evaluate access and quality of care issues in the Alaska VA Healthcare System. Specifically, the allegations were:

- The system did not maintain adequate provider staffing at the Mat-Su VA CBOC.
- The Mat-Su VA CBOC's lack of adequate provider staffing resulted in poor access to care for veterans which in turn compromised the quality of care provided.
- The Mat-Su VA CBOC has had security issues since opening in 2009.
- In 2008, the system engaged in improper scheduling practices.
- In 2008, the system failed to ensure adequate follow-up for patients after the departure of a urologist resulting in delays in care and impacting the quality of care.

During the course of our review, we received another complaint via Senator Murkowski's office regarding access issues at Anchorage and the Mat-Su VA CBOC. Specifically the allegation was:

- A patient was unable to obtain an appointment with a provider at either the Mat-Su VA CBOC or at the Anchorage VA Outpatient Clinic.

The Office of Healthcare Inspections initiated a review in August 2014 in response to these allegations.

Scope and Methodology

We requested and reviewed extensive system documentation, including VHA handbooks and directives; JC Standards; system policies and procedures; electronic health records (EHR); quality management and staffing documents; scheduling, access,

and performance data; committee minutes; patient complaints; police reports; and environment of care/facility management information and records.

To evaluate quality of care issues related to alleged decreased access at the Mat-Su VA CBOC, we reviewed the records of all patients assigned to the Mat-Su VA CBOC who died between July 24, 2013, and July 31, 2014. We identified 40 patients meeting these criteria. We excluded one patient from further review because that patient had never been seen at the CBOC, nor was there documentation that the patient had requested an appointment with a provider at the Mat-Su VA CBOC. We reviewed the EHRs of the remaining 39 patients to determine whether they received poor access to care at the Mat-Su VA CBOC. We also reviewed the EHR of the patient referenced in the additional complaint pertaining to access at the Mat-Su VA CBOC and the Anchorage Outpatient Clinic.

To determine access to urology care in 2008 following the departure of the system's only urologist, we reviewed the records of eight patients identified by the urologist as needing follow-up care. As that was a small number, we also looked at timeliness of access for any patients with a consult for urological services in the 3 months immediately following that urologist's departure.

The period of review was August 12, 2014, through March 5, 2015. We conducted a site visit September 22–24, 2014, and went to the Anchorage Outpatient Clinic and the Mat-Su VA CBOC. We interviewed the Director, Associate Director, Chief of Staff (COS), and the Associate Director for Patient Care Services. We conducted interviews with directors, mid-level managers, providers, and other clinical and administrative staff knowledgeable about the system's quality, scheduling, and security processes. At the time of the onsite inspection there were no permanent providers assigned to the Mat-Su VA CBOC.

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

Inspection Results

Issue 1: Mat-Su VA CBOC Provider Staffing and Workload

We substantiated the allegation that the Mat-Su VA CBOC did not maintain adequate provider staffing. Panel sizes—patients assigned to a specific primary care provider (PCP) or primary care (PC) team—were within VHA targets until July 2012 when one of the two permanent physician providers resigned. Since that time, the Mat-Su VA CBOC has struggled to provide consistent PC staffing. The impact of inadequate provider staffing on access for patients is discussed in Issue 2.

Provider Staffing

The Mat-Su VA CBOC opened in March 2009. A full-time permanent provider (Provider 1) was hired within 6 months. A second permanent provider (Provider 2) was hired in April 2011 and stayed until July 2012. After Provider 2 resigned in July 2012, providers from other locations (Anchorage, Fairbanks, and Juneau) assisted at the Mat-Su VA CBOC on an intermittent basis. However, we found no documented evidence that additional provider assistance was consistently available until summer 2013 when a locum tenens provider³ worked at the clinic from May to August 2013. Provider 1 resigned in May 2014 citing excessive workload. After May 2, 2014, although the clinic remained open, it did not have a permanent provider. Rather, the CBOC was staffed by contract physicians and a nurse practitioner detailed from Anchorage. In September 2014, the system advertised for a nurse practitioner for the Mat-Su VA CBOC, and the position was filled in October 2014. As of March 2015, the Mat-Su VA CBOC has a permanent provider but not a permanent physician. The system continues to refer patients elsewhere for care at VA expense because patient demand continues to exceed provider supply and appointment availability at the Mat-Su VA CBOC.

While interviews and data revealed that in the summer of 2013 the system increased provider supply to address the patient demand by hiring the locum tenens physician, no locum tenens or contract providers were hired in the summer of 2012 following the departure of Provider 2. Between 2012 and 2014 there were 66 days (3–6 weeks annually) where the clinic was open and patients were being seen by nursing staff, but there were no providers. These 66 days without a provider onsite are noted in Appendix A at the end of the report. Appendix A also shows all provider staffing from the time of Provider 2's departure, July 2012 through December 2014. Provider 1 stopped seeing patients in April 2014.

³ Locum tenens is a Latin phrase that means "to hold the place of, to substitute for." Locum tenens staffing began in the early 1970s with a federal grant to provide physician staffing services to rural health clinics in medically underserved areas of the western United States. The program proved so successful that today locum tenens companies provide physician staffing services for hospitals, outpatient medical centers, government and military facilities, group practices, community health centers and correctional facilities. www.locumtenens.com Accessed 01.16.15

When no providers were available on-site, Patient Aligned Care Team (PACT) team staff (nursing and medical support assistants) provided care management, such as triage, and would send patients to local urgent care facilities and the Emergency Department (ED) when needed. Surrogate providers were assigned to review and manage Mat-Su VA CBOC alerts and to recommend nursing team actions as required.

Panel Sizes

VHA discusses panel sizes, primary care staffing, and workload expectations in VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009.⁴ VHA mandates the use of the PCMM software program to manage PC patient panels. Use of this software allows facilities to track patients and their assigned PCP throughout the system and allows VHA to monitor and analyze system and PCP workload nationally, by VISN, by facility, and by substations such as CBOCs. The expectation outlined in VHA policy is that a patient load (panel size) of 1,200 patients is “maximum capacity” for a full-time physician provider. The panel size expected of a mid-level provider (nurse practitioner or physician assistant) is 900 patients. Provider staffing at the Mat-Su VA CBOC since opening in 2009 has been a combination of permanent and temporary providers (see above discussion).

In our review of the CBOC’s panel capacity data, panel size first began to exceed VHA expectations of 1,200 patients per physician provider in July 2012, when a second permanent provider (Provider 2), hired at the clinic in 2011, resigned. Provider 1 was left to assume responsibility for a panel size of approximately 1,700 patients, which exceeded the expected panel size for a 1.0 full-time equivalent physician provider by 500 patients.

This increased workload, with one exception, continued until May 2014 when Provider 1 resigned. From May to August 2013, the facility brought on an additional provider, temporary not permanent, through the VA Locum Tenens Program.⁵ Other than this 3-month period of relief, the panel capacity remained 20–40 percent in excess of VHA targets throughout some of 2012, all of 2013, and some of 2014.

Documentation and interviews confirm that provider recruitment efforts were made but were unsuccessful. Interviewees cited minimal support from system management to fill the provider vacancies and conveyed that Human Resources processes were significantly delayed to the point of losing out on at least one potential provider. Multiple employees, as well the system Director, Associate Director of Patient Care Services, COS, and other clinical leadership, cited provider recruitment and retention as one of their biggest challenges. While leadership spoke about this being a longstanding and

⁴ VHA Handbook 1101.02, *Primary Care Management Module*, April 21, 2009. This VHA Handbook was scheduled for recertification by March 2014 but has not yet been recertified.

⁵ The VA Locum Tenens Program assists facilities with short-term provider staffing needs. Physicians, Nurse Practitioners and Physician Assistants must be Board Eligible or Board Certified in Internal Medicine or Family Practice to participate in the program. <http://www.vacareers.va.gov/careers/physicians/locum-tenens.asp>. Accessed February 14, 2015.

ongoing concern, the system does not have a Recruitment and Retention Plan and, at the time of our onsite visit, had no Director of Human Resources.

We found that Mat-Su VA CBOC provider staffing issues decreased patients' access to care.

Issue 2: Access to Care and Quality of Care Concerns at the Mat-Su VA CBOC

We substantiated that the lack of providers at the Mat-Su VA CBOC resulted in poor access to care for some patients, which in turn resulted in poor quality of care.

Panel sizes, in conjunction with other information such as encounter data and wait times, serve as indicators of the adequacy of provider staffing to meet demand. We determined in Issue 1 that the system did not maintain an adequate number of providers at the Mat-Su VA CBOC. These staffing challenges contributed to wait times greater than VHA's access performance measure goals.

Wait Times

VHA Primary Care Access Measures in FY 2012, 2013, and 2014 (revised in October 2014) had targets for both new and established patients to have completed appointments within 14 days from the create date. Review of panel capacity, access, and wait time data for the Mat-Su VA CBOC in FY 2013 and FY 2014 revealed that new patients often had to wait more than 14 days to complete a primary care appointment. Eleven of the 12 months in FY 2013 showed an average wait time for new patients exceeding 14 days. Six of the 12 months had a wait time over 19 days with the highest being 27 days (this occurred in October 2012). Access for new patients was not much better in FY 2014. Seven of the 12 months in FY 2014 showed an average wait time for new patients exceeding 14 days; 3 of the months had a wait time of over 19 days with the highest being 34 days (March 2014). Insufficient provider staffing contributed to wait times which exceeded those recommended under VHA policy.

**Table 1. Average Wait Time for a New Patient in Number of Days
(VHA target: 14 days)**

FY 2013											
10/2012	11/2012	12/2012	1/2013	2/2013	3/2013	4/2013	5/2013	6/2013	7/2013	8/2013	9/2013
27.7	25.9	13.7	21.5	15.6	16.3	17	15	19.3	26.2	22.2	14.8
FY 2014											
10/2013	11/2013	12/2013	1/2014	2/2014	3/2014	4/2014	5/2014	6/2014	7/2014	8/2014	9/2014
17.2	22.5	26.2	16.6	18.5	34.1	18.1	5.2	8.4	9.2	13.1	5

Source: VHA Data

Electronic Wait List⁶

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, states that the electronic wait list (EWL) is the official VHA wait list for outpatient clinical care appointments and is to be used to list patients waiting to be scheduled or waiting to be assigned a PCP. The EWL tracks new patients with whom the provider does not have an established relationship, for example, the patient has not been seen before in the clinic at that facility.⁷

Starting in June 2012, new patients to the Mat-Su VA CBOC were placed on an EWL. Data was not maintained for July through August 2012, but in November 2012, the EWL was 40 and increased each month going into 2013. From February to July 2013, the EWL was active with approximately 100–200 patients each month. After July 2013, fewer patients went on the EWL, as many new patients were referred to another care provider in the community via Non-VA Care or through a Service and Reimbursement Agreement. From August 2013 through February 2014 there were 3 patients on the EWL, and then in March 2014, it went up to 42 before returning to 3 in April 2014. From April 2014 through February 2015, the EWL at Mat-Su VA CBOC ranged from 0 to 10. These numbers show that the CBOC was at capacity with limited provider staffing and was unable to meet demand for timely access to care for new patients.

Reimbursement and Service Agreement with Southcentral Foundation

Community partners are an integral part of the health care delivery system, especially in states like Alaska that have significant rural and frontier areas. In May 2012 the system signed a Reimbursement and Service Agreement with the Southcentral Foundation (SCF), an Alaska Native-owned, nonprofit health care organization with a clinic in Wasilla, the same town where the Mat-Su VA CBOC is located. One way the system responded to the unmet need of patients wanting to establish care but being unable to get timely appointments at the CBOC, was to provide VA-paid care to new patients through its arrangement with SCF. From June 2013 through February 2015, 509 patients not previously cared for by the VA who wanted to initiate care at the Mat-Su VA CBOC but could not due to the provider shortage and 535 established patients who could not get into the Mat-Su VA CBOC timely received care at VA expense at SCF. Patients continue to be referred to SCF for VA-paid care as recently as February 26, 2015.

In addition, from August 2013 to February 2015, 123 new patients and 30 established patients who could not get timely appointments at the Mat-Su VA CBOC had care purchased in the community (Non-VA Care) at the Sunshine Community Health Center, a federally funded health center, the Providence Mat-Su Clinic, or with a provider in private practice in the Mat-Su Valley.

⁶ The EWL is the official VHA wait list. The EWL is used to list patients waiting to be scheduled, or waiting for a panel assignment.

⁷ VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (Appendix G), June 9, 2010.

Access and Quality of Care – Patient Cases

Wait times are one measure of access to care, but are not the only measure. For purposes of this review, OIG defined poor access as either (1) a frequency of follow-up that did not comply with nationally recognized clinical guidelines, or (2) a frequency of follow-up that did not coincide with the provider's recommendations, or (3) follow-up that did not comply with VHA policy regarding access to primary care. Of the 40 patients assigned to the Mat-Su VA CBOC who died between July 2013 and July 2014, we identified 8 patients who had poor access to care using this definition. We then determined the impact of poor access on the quality of care these eight patients received from the Mat-Su VA CBOC.

In addition, we determined the impact poor access had on the care for the one additional patient whose concerns were brought to our attention during the course of our review. This added patient is identified as Patient 9. The challenges faced by these nine patients seeking care at the Mat-Su VA CBOC during 2013 and 2014 are described below.

Patient 1 – Patient 1 was in his 80s with a history of coronary artery disease, diabetes, an abnormal heart rhythm, and melanoma. Medications he received through the Mat-Su VA CBOC included glipizide, which lowers blood sugar, as well as other drugs for his diabetes and heart condition. At the time of his last visit to the Mat-Su VA CBOC in early winter 2013, his provider instructed him to return to clinic in 6 months (spring 2014) for laboratory tests and a follow-up appointment. The patient presented to the Mat-Su VA CBOC for these tests in spring 2014 after the departure of the last permanent provider. The tests included a measure of the patient's long term diabetes control, an HbA1C level.⁸ All previous HbA1Cs in the patient's record had been greater than 6.0 percent (the higher the HbA1C, the higher the patient's blood sugar has been over the past 6 months). The spring HbA1C demonstrated a significant decline from previous levels to 5.5 percent. Glipizide lowers HbA1C and can result in dangerous drops in blood sugar, especially in the elderly, if the patient's blood sugar levels are not monitored appropriately. In this instance, despite the decline in HbA1C in an elderly patient receiving glipizide, the patient did not see a Mat-Su VA CBOC provider, nor is it documented that laboratory tests performed in spring were reviewed by a provider prior to the patient's death in the summer of 2014. Following the patient's spring laboratory visit, the only entries in the EHR include a consult to ophthalmology and an administrative note recording the patient's death.

We concluded that this patient received poor access to care in that he did not receive an appointment within the timeframe recommended by his provider. Further, we concluded that poor access resulted in poor quality of care because a provider did not review the laboratory test results to determine whether a change in the patient's

⁸ HbA1C measurements reflect glucose levels over the preceding 3 months and are a diagnostic indicator for Diabetes Mellitus and Impaired Glucose Regulation. HbA1C < 5.7 is considered normal, 5.7–6.4 signifies impaired glucose regulation, and >= 6.5 indicates Diabetes. www.merckmanuals.com Accessed 01.29.14.

treatment plan, such as closer monitoring for low blood sugar levels, or adjustments to the glipizide dose, was required.

Patient 2 – Patient 2 was in his 70s with multiple serious medical conditions including kidney disease. He was last seen by a provider at the Mat-Su VA CBOC in winter 2013 and had VA laboratory studies done in early 2014. His kidney disease was stable, and a cholesterol panel from winter 2013 was near treatment goals. His provider requested that he follow up in 6 months (summer 2014). This appointment was never scheduled because the patient’s provider left the Mat-Su VA CBOC in spring 2014. However, in late early spring 2014, the patient went to a non-VA ED with severe back pain. He was discharged with the diagnosis of shingles and sent home. Five days later, he became incontinent and complained of pain and burning on urination. He contacted a nurse at the Mat-Su VA CBOC who instructed him to go to an ED or urgent care clinic.

He was admitted to a non-VA hospital with urosepsis,⁹ treated, and subsequently discharged on an antibiotic after a 3-day stay. The results of a bacterial culture done to determine the type of bacteria causing the infection as well as what antibiotics would best treat the condition were sent to a VA provider in Anchorage. The VA provider in Anchorage discovered that the cultured organism was not sensitive to the antibiotic prescribed. He called the patient and told him to pick up a new antibiotic at the VA clinic in Anchorage but to take the antibiotic that had been ordered at the time of discharge until he could get to the clinic. The Anchorage provider also told him to “return to ER or seek other medical attention” if his condition worsened. He did not offer the patient a follow-up appointment at either Anchorage or with an interim provider at the Mat-Su VA CBOC. According to the patient’s EHR, he did not pick up the new antibiotic.

Four days after discharge from the non-VA hospital, the patient’s son called the Mat-Su VA CBOC to report that his father’s condition had worsened. He was instructed to call emergency services to transport the patient to an ED. The patient was subsequently readmitted to an outside hospital and found to have worsening kidney disease, an infection in the bloodstream, and an enterovesicular fistula.¹⁰ The patient died at the outside facility following a surgical procedure to repair the enterovesicular fistula.

We concluded that this patient received poor access to care because the access provided in the month prior to his death did not reflect adequate contingency planning by the facility. VHA policy¹¹ states:

Local service-level officials accountable for PACTs¹² must establish and implement contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and

⁹ Urosepsis is an infection that starts in the urinary tract but then enters the bloodstream.

¹⁰ An enterovesicular fistula is an abnormal communication between the bladder and the bowel.

¹¹ VHA Patient Aligned Care Team (PACT) Handbook 1101.10, February 5, 2014.

¹² In 2009 VHA adopted and customized the patient-centered medical home model of care and branded VHA’s patient-centered medical home model as the Patient Aligned Care Team.

*nature-related events (e.g., extreme weather conditions, natural disasters).*¹³

The patient's EHR does not document that he or his family members were advised, before or after his visits to outside facilities for urosepsis or back pain, that the patient could receive primary care or urgent care at the Anchorage facility, or another VA facility, or that an urgent appointment would be arranged with a community provider. Even in the absence of acute medical issues, this patient was due for a primary care appointment in summer 2014. There is no evidence in the EHR that the facility had arranged for this follow-up appointment to occur elsewhere or in the VA. Because primary care was not available at the CBOC prior to or following this patient's hospitalizations, and because a follow-up appointment had not been arranged for the patient in the timeframe requested by the Mat-Su VA provider, the care provided to this patient did not reflect adequate contingency planning for staff departures, as required under VA policy.

While we concluded that the patient received poor access to care, we did not reach a conclusion regarding the quality of care this patient received immediately prior to his death because the scope of this review is limited to the quality of care provided at the Mat-Su VA CBOC. No Mat-Su VA provider saw him following his last regularly scheduled appointment in November of 2013.

Patient 3 – Patient 3 was in his early 90s with a history of coronary artery disease, an abdominal aortic aneurysm,¹⁴ high blood pressure, and an elevated cholesterol level. He was last seen in winter 2012 by a Mat-Su VA CBOC provider for pre-operative clearance for cataract surgery. Labs drawn at that time demonstrated mild anemia¹⁵ but were otherwise unremarkable. In fall 2013, the patient was transferred to another Mat-Su VA provider who noted that the patient had not been seen in the CBOC for 18 months. She requested that the patient be scheduled for a primary care appointment with fasting laboratory work. The appointment was not scheduled. The patient next came to the clinic in spring 2014, to receive information about the clinic's plans to transfer him to the care of a non-VA primary care provider. He received an appointment for non-VA care for summer 2014. Within a month, however, he returned to a non-VA ED with complaints of gait instability, vomiting, and difficulty swallowing. The patient was admitted with the diagnosis of hyponatremia (low sodium). When last evaluated at the Mat-Su VA CBOC, the patient's sodium level had been within normal limits.

The patient requested discharge from the non-VA hospital despite a persistently low sodium level. The patient was discharged with instructions to obtain a repeat sodium level 2 days after discharge. A nurse at the Mat-Su VA CBOC and an Anchorage provider acknowledged receipt of these records on day 3 and 4 after discharge;

¹³ VHA Patient Aligned Care Team (PACT) Handbook, February 5, 2014, p. 12–13.

¹⁴ A thinning and widening of the wall of the abdominal aorta, which can rupture if the aneurysm reaches a certain size.

¹⁵ Anemia is a low red blood cell count, which can be seen in many different health conditions.

however, we could find no documentation in the EHR that the patient received additional laboratory testing or was seen by a VA provider before his death approximately 3 weeks later. His EHR does not contain evidence that either the Anchorage provider or Mat-Su VA CBOC staff attempted to contact him to arrange the appropriate testing and follow-up for his low sodium level. The facility had previously arranged for non-VA primary care for this patient, but his first appointment with the external PCP was to take place in summer 2014, by which time the patient had died.

We concluded that the patient received poor access to care in that he did not receive an appointment within the timeframe requested by his primary care provider in 2012, and he did not receive follow-up labs during the recommended timeframe after discharge from the non-VA hospital for the low sodium level. Further, because persistently low sodium levels may be a life-threatening condition, we concluded the patient received poor quality of care from the VA because the patient's sodium upon discharge warranted urgent evaluation after discharge to determine whether the patient required additional treatment.

Patient 4 – Patient 4's daughter first contacted the Mat-Su VA CBOC, in winter 2012, and informed clinic personnel that she needed an appointment for her father as soon as possible because he had advanced Alzheimer's disease and needed to obtain his medications through the VA. She was informed that the clinic had an EWL for new patients. She requested a call back from the Anchorage VA. There is no documentation that she received this call. The next note in the EHR was entered in summer 2013. This note indicates the patient was assigned to a non-VA PCP, and an appointment was arranged for fall 2013, more than 9 months after the patient's request for an appointment as soon as possible. The patient died in spring 2014.

We concluded the patient received poor access to care. We did not reach a conclusion about the quality of care this patient received as the patient was not seen by a Mat-Su VA provider prior to his death.

Patient 5 – Patient 5 was in his 60s with a history of high blood pressure, diabetes, tobacco use, and elevated cholesterol levels. At the time of his last visit to his Mat-Su VA CBOC provider in winter 2012, his blood pressure was within normal limits,¹⁶ and he weighed 216 pounds. Laboratory tests were drawn in early 2013 and again in spring 2013. The patient's triglycerides level was elevated¹⁷ and LDL level was borderline high.¹⁸ The patient had not tolerated statin drugs in the past due to muscle aches. His

¹⁶ Blood pressure equals cardiac output x total peripheral vascular resistance: normal BP is <120/80 mm Hg; prehypertension is defined as 120–139/80–89, Stage 1 hypertension is 140–159/90–99, and Stage 2 hypertension is \geq 160 systolic or \geq 100 diastolic. www.merckmanual.com Accessed 01.29.15.

¹⁷ TG (triglycerides): there is no natural cutoff between normal and abnormal lipid levels because lipid measurements are continuous; however, in general <150 is desirable, 150–199 is borderline high, 200–499 is high. www.merckmanuals.com Accessed 01.29.15.

¹⁸ LDL (low-density lipoprotein) cholesterol: there is no natural cutoff between normal and abnormal lipid levels because lipid measurements are continuous; however, in general <100 is optimal, 100–129 is near optimal/above optimal, 130–159 is borderline high, 160–189 is high, and \geq 190 is very high. www.merckmanuals.com Accessed 01.29.15.

HbA1C demonstrated good control of his diabetes. The Mat-Su VA provider started gemfibrozil, then stopped this medication, and started colestipol for continued elevations in the patient's cholesterol. However, the patient was not seen again in the clinic before his death in early spring 2014, 15 months after his last physician visit and 10 months since his last laboratory tests.

VA/DOD guidelines for cholesterol, published in 2006,¹⁹ were in effect at the time this patient was receiving care at the Mat-Su VA CBOC. These guidelines recommended that patients on gemfibrozil, niacin, or other medications such as colestipol for cholesterol receive laboratory tests every 6–12 weeks initially and then at least every 6–12 months once patients are on a stable regimen. Likewise, in 2013, the American College of Cardiology and the American Heart Association published guidelines on the treatment of elevated cholesterol to reduce cardiovascular risk in adults.²⁰ These guidelines recommended that patients with high cholesterol on treatment for that cholesterol receive follow-up lipid profiles every 3–12 months to assess response and adherence to medication management. This patient received no laboratory testing in the 10 months prior to his death.

We concluded that this patient received poor access to care because the frequency of follow-up did not comply with nationally recognized clinical guidelines. We further concluded he received poor quality of care, as opportunities may have been missed to lower his risk for cardiovascular disease.

Patient 6 – Patient 6 was in his 80s and last saw a provider at the Mat-Su VA CBOC in fall 2012.

In winter 2013, the patient fell and sustained an incomplete tetraplegia.²¹ He was flown to the VA Puget Sound Health Care System (VAPSHCS) in Seattle, where he received care and rehabilitation. After his discharge from the rehabilitation facility in Seattle, the patient was admitted to a long term care facility in Alaska. In spring 2013, a spinal cord injury physician from VAPSHCS asked the Mat-Su VA provider to facilitate local neurosurgical care for his tetraplegia, as the patient was unable to travel easily to Seattle. In addition, the patient's daughter contacted the CBOC requesting an order for a follow-up positron emission tomography (PET) scan for her father. She was told by Mat-Su VA CBOC staff that if the PCP at the long term care facility had a contract with VA, that provider could order the PET scan. The EHR does not include a referral to a local neurosurgeon, results of a PET scan, or documentation that the PET scan was done. The EHR does not reflect that the patient's care was transferred to the provider at the long term care facility, and the family continued to contact the Mat-Su VA CBOC for services.

Because of the patient's tetraplegia, the VAPSHCS spinal cord unit physician had recommended a specialized wheelchair, which was available at the Seattle facility. The

¹⁹ http://www.healthquality.va.gov/guidelines/CD/lipids/lip05_950_final2.pdf

²⁰ http://circ.ahajournals.org/content/129/25_suppl_2/S1.extract

²¹ Tetraplegia, also known as quadriplegia, is paralysis resulting in the partial or total loss of use of all their limbs and torso.

daughter called the CBOC in the spring, complaining that the patient had made no progress at the long term care facility because the recommended wheelchair had not been shipped to Anchorage from Seattle. The social worker taking the daughter's call wrote that the wheelchair had not arrived because there were difficulties in securing payment and appropriate UPS stickers for shipping. The wheelchair was ultimately received 18 months after his admission to the long term care facility. The patient died approximately 21 months since the date he was last seen by a provider at the Mat-Su VA CBOC.

We concluded that the patient received poor access to care because the patient did not receive local neurosurgical care as recommended by the VAPSHCS provider. We further concluded the patient received poor quality of care because the Mat-Su VA CBOC provider did not ensure the patient received appropriate durable medical equipment once the patient had been returned to his/her care.

Patient 7 – Patient 7 was in his 60s with a history of a seizure disorder, bladder cancer, tobacco use, and colonic polyps who was last seen at the Mat-Su VA CBOC on December 13, 2013. In fall 2012, he saw a non-VA urologist for follow-up of his bladder cancer. The urologist performed a cystoscopy and found recurrent lesions of the bladder, which were treated with surgical excision. Following this procedure, the urologist recommended that the patient receive cystoscopy every 3 months. He did not have follow-up cystoscopy between the fall 2012 urology visit and his last visit to his CBOC provider in winter 2013. In the winter 2013 EHR entry, the Mat-Su provider did not document discussion of the recommendation for the patient to have a cystoscopy every 3 months.²² Later in the winter of 2014, the patient called the CBOC, saying that he did not feel well and requested an appointment. He was told there was no capacity in the CBOC and directed to the nearest ED. He presented to the local ED the following day, with multi-lobar pneumonia, septic shock, and possible metastatic bladder cancer. He declined intubation and expired the next day.

VHA policy requires primary care teams to maintain capacity for same day appointments. VHA Handbook 1101.10 states:

*All PCPs and RNs must ensure they have same-day access (unless it is too late in the day as determined by the individual facility) for face-to-face encounters, telephone encounters and, when required by VHA guidance or policy, other types of encounters.*²³

We concluded that this patient received poor access to care because the clinic did not have same-day appointments as required under VHA policy nor did the patient receive the follow-up recommended by his urology providers. Because the primary care provider at the Mat-Su VA CBOC failed to address follow-up recommendations for cystoscopy, we further concluded that the patient received poor quality of care.

²² The non-VA urology records were available for review in the patient's VA EHR record.

²³ VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, p. 18–19, February 5, 2014. This Handbook was issued prior to the patient's call to the CBOC in winter 2014

Patient 8 – Patient 8 was in his 70s with a history of coronary artery disease, high cholesterol, and malignant melanoma located on the right shoulder (diagnosed in winter 2013) who last saw a provider at the Mat-Su VA CBOC in late winter 2013. In spring 2013, the patient received a teledermatology consult for follow-up of his melanoma. At that time, no further treatment was recommended other than routine follow-up with his PCP and in a dermatology clinic every 6 months. There is no evidence the patient had further follow-up from dermatology after spring 2013.

In fall 2013, the patient presented to the Mat-Su VA CBOC for a routine appointment complaining of bilateral shoulder pain. He described the pain as a “pounding” pain which woke him up at night, and he was referred to orthopedics based on degenerative changes on x-rays of the shoulder. An orthopedic provider saw the patient a week later, noted full range of motion of both shoulders, but diagnosed him with an impingement syndrome.²⁴ The patient received a steroid injection, which initially relieved his pain. However a few weeks later, the patient called the CBOC reporting continuing pain in his shoulder and asking about appropriate use of non-steroidal anti-inflammatory medications. A nurse talked with the patient on the phone and instructed him on how to take the anti-inflammatory medications. The Mat-Su VA provider acknowledged reviewing the nurse’s note regarding the phone call. The patient returned to the Mat-Su VA CBOC in spring 2014 for routine laboratory testing for his cholesterol. The CBOC sent the patient a letter notifying him that his results were normal, but there is no evidence the patient had a follow-up appointment scheduled at the CBOC.

One month later, he presented to a non-VA ED with complaints of ongoing, severe, and worsening shoulder pain. The ED physician, concerned about the possibility of metastatic melanoma, ordered a chest computed tomography (CT) scan. This scan identified multiple lesions throughout the chest. The patient was admitted and diagnosed with metastatic melanoma. The clinic scheduled a follow-up appointment, but the patient did not come and did not call to cancel the appointment. He was subsequently admitted to hospice where he died a few weeks later.

VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, dated February 5, 2014, describes the obligation of the PCP to coordinate care for complex patients. It states that care coordination processes must be sufficient to ensure PACT staff coordinates care for patients assigned to the PACT in the following situations:

- Receiving care from provider(s) of specialty care.
- Receiving care from several health care providers, including VA providers, VA-contract providers, or providers unaffiliated with VA (for example, dual care).

In addition, VHA policy states that care coordination processes must ensure the following:

- There is no lapse in care for the patient.

²⁴ Shoulder impingement syndrome is an inflammation of the tendons of the rotator cuff in the shoulder, caused by a narrowing of the space between the acromion (part of the shoulder blade) and the humerus (bone in the upper arm).

- Relevant information is communicated to involved providers. Communications between providers need to ensure that during the transition the receiving provider is provided with necessary information for health care decision-making.
- PACT staff knows about transitions of assigned patients between care settings and are involved when needed to facilitate safe, effective, and patient-centered transitions.
- Health record information is made accessible to involved providers in a timely manner.
- Clinically recommended care is integrated to avoid duplication, poor timing, or missed care opportunities.

We concluded that this patient received poor access to care because follow-up recommendations from teledermatology were not followed. This resulted in poor quality of care because the CBOC provider neither coordinated care for the patient's malignant melanoma with a specialist nor assumed responsibility for regular surveillance of the patient's condition.

During the course of this review, we also received allegations regarding the inability of a patient to be seen at either the Anchorage or at the Mat-Su VA CBOC. This patient's care is reviewed below.

Patient 9 – At the time of our review, the patient was in his 40s with a history of diabetes, high cholesterol, and gastroesophageal reflux disease. He called the Mat-Su VA CBOC in spring 2014 with complaints of an elevated blood sugar and asked whether his dose of a diabetes medication should be increased. The Mat-Su VA CBOC provider's last day was a few days after his call; this patient complained that his provider left the Mat-Su VA CBOC because of being overworked. A nurse at the clinic informed him that he should keep a food log and attend diabetic coaching. The EHR does not reflect that a provider reviewed this triage decision. VHA Directive 2012-011, *Primary Care Standards*, specifically states, "Telephone triage personnel must communicate with assigned primary care providers regarding patients' concerns and triage decisions."²⁵

In mid-summer, the patient presented to an outside ED with complaints of chest pain. He was observed and then discharged with follow-up by a community cardiologist. On receipt of the records from the outside ED approximately 1 week later, Mat-Su VA CBOC staff documented that the patient would be scheduled for the next available hospital follow-up appointment at the Mat-Su VA CBOC. The EHR does not document this visit was scheduled. Instead, about 6 weeks after the ED visit, the patient was contacted to change his PCP to a non-VA provider. During this phone call, the patient instead requested a VA provider in Anchorage.

²⁵ VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012, p.3.

Five days later, the patient called the Mat-Su VA CBOC with a blood sugar of 240²⁶ after being prescribed antibiotics and steroids at a walk-in clinic. A nurse informed him that she had discussed this with a provider, and he should go to an ED or urgent care clinic if his blood sugar reached 400. The patient informed the nurse that he had changed his mind and preferred to continue care in the Mat-Su area. The EHR does not contain documentation regarding the result of this request until, approximately 3 months after the patient's mid-summer hospitalization when the patient received a telehealth appointment with a provider.

We substantiated that the patient was not offered an appointment at the Anchorage Outpatient Clinic but note that, according to his EHR, he told Mat-Su VA CBOC staff that he had changed his mind and wanted to continue care at the Mat-Su VA CBOC 5 days after his initial request to see an Anchorage provider. We further substantiated that he received poor access to care at the Mat-Su clinic because he did not receive an appointment with a primary care provider for 3 months after his hospitalization and that the only option available to him for an elevated blood sugar was to go to the ED or an urgent care clinic. CBOCs are required to offer same-day access to appointments for urgent needs. Further, the absence of documentation that triage decisions were consistently discussed with a provider violated VHA policy and constituted poor quality of care.

Summary Findings of Access and Quality of Care

Because of ongoing insufficient provider supply, yet continued demand, patients' ability to establish and receive care at the CBOC was delayed. We substantiated that the Mat-Su VA CBOC lacked a permanent provider and that provider staffing and workload issues resulted in wait times that did not meet VA targets at the time. We do note that the system made some efforts to obtain care for these patients in the community and through the use of locum tenens and contract providers.

For the nine patients whose care is summarized above, we determined that all nine received poor access to care at the Mat-Su VA CBOC. For seven of these nine patients, this delay resulted in poor quality of care. Poor quality of care most commonly resulted from the failure of the PACT teams, functioning without permanent providers, to coordinate care, to include implementation of specialist recommendations; to ensure consistent coverage of patient care needs from other facilities, such as Anchorage; and to schedule same day appointments. We were unable to determine the effect delayed access to care had on the quality of care for two of the nine patients, as the scope of this review is limited to the quality of care provided at the Mat-Su VA CBOC and no Mat-Su VA provider saw these two patients prior to their deaths.

²⁶ Blood glucose between 80 and 120 mg/dL during the day (higher at bedtime) is considered the goal for glycemic control. www.mercksmannual.com Accessed 01.29.15.

Issue 3: Mat-Su VA CBOC Security

We did not substantiate the allegation that “since its opening, this clinic has been plagued by security issues.”

The Mat-Su VA CBOC opened in March 2009. According to the Occupational Safety and Health Administration, health care workers experience a significant risk of job-related violence.²⁷ VA requires that police chiefs conduct comprehensive vulnerability assessments of all Department properties within their jurisdiction at least once every 2 years. The assessment is conducted to determine the facility’s ability to deter threats, contain incidents, and respond or recover from a serious incident. We reviewed vulnerability assessments completed for the Mat-Su VA CBOC and found they were performed as required. Physical security surveys, limited in scope to an individual program, building, or room, are required to be conducted annually to ensure the effective planning and utilization of security resources. The six physical security surveys performed at the Mat-Su VA CBOC met VA Handbook 0730/1, *Security and Law Enforcement*, handbook requirements.²⁸

VHA also requires that appropriate physical security precautions and equipment is implemented and used. For two of six Mat-Su VA CBOC physical security surveys that made recommendations for improvement above directive requirements, there was documentation of follow-up and resolution of the recommendations as required.

The system implemented policies for managing disruptive behavior, conducted an annual risk assessment, and established a prevention and management of disruptive behavior program. The system’s program included a reporting and tracking method as required, therefore ensuring that behaviors which undermine a safe and healing environment are appropriately reported, addressed, and monitored.

VHA has established procedures for the reporting of adverse and sentinel events. Incident reports reviewed for the Mat-Su VA CBOC revealed reporting processes were in place and generally in alignment with handbook requirements.

We interviewed staff and reviewed records of Environment of Care rounds at the Mat-Su VA CBOC. Documentation of identification of deficiencies, progress toward resolution, and tracking of items to closure were present as required by JC.

Issue 4: System Failure To Maintain Appropriate Scheduling Practices in 2008

We substantiated that the system did not comply with VHA scheduling directives in 2008 but did not find evidence of current scheduling irregularities.

Prior to December 2009, the system’s local scheduling policy and procedures were not in compliance with VHA requirements. The VHA Directive active at that time required

²⁷ Occupational Safety and Health Administration 3148-01R, *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*, 2004.

²⁸ VA Handbook 0730/1, *Security and Law Enforcement*, August 20, 2004.

outpatient visits to be scheduled according to the desired date, defined as the earliest appointment date specified by the patient or provider. In May 2008, the system created a local scheduling policy that updated its approach to scheduling patient appointments. The local policy required employees with access to schedule appointments, to schedule the first available appointment for each patient, then contact the patient with the appointment date and time to inquire if it met the patient's need. If the patient did not agree to the offered appointment, the appointment was canceled, coded as canceled by patient, and rescheduled. We identified through interviews and document review that after the implementation of the May 2008 policy, employees reported concerns to system leadership regarding compliance with the VHA scheduling directive in effect at that time. In a memorandum to the Network Directors from the Deputy Under Secretary for Health for Operations and Management, dated June 11, 2008, VHA clarified its commitment to providing clinically appropriate quality care for eligible veterans when they want and need it with the performance goal at the time of 14 days for a follow-up appointment in mental health and 30 days for other services.

In August 2008, the local scheduling policy was referred to the system's Integrated Ethics Program and Executive Committee of the Medical Staff for review. The system made no changes to the policy.

VHA Directive 2009-070, *VHA Outpatient Scheduling Processes and Procedures*, published December 17, 2009, required schedulers to ask the patient the first date they would like to be seen, which was to be used as the desired date for the appointment. While in discussions regarding the draft of directive, the system determined in May 2009 that its local policy of scheduling an appointment for the patient, then calling to inform the patient of the appointment, would not meet the anticipated new requirement and started the process of updating its policy.

In June 2010, VHA again revised outpatient scheduling requirements in VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, which further clarified the desired date. The desired date was to be defined by the patient or provider without regard to schedule capacity and once established, the appointment must not be altered to reflect a date the patient agreed to accept for lack of appointment availability on the desired date. The system's current scheduling policy is in alignment with the VHA scheduling directive. In addition, the system conducted education for all scheduling employees on the revised local scheduling policy and the VHA directive.

Onsite, we interviewed multiple staff involved in the scheduling process. Review of the system's future pending appointments and EWL indicated that 69 patients were waiting for appointments beyond 30 days as of December 15, 2014. None of the patients waiting beyond 30 days received care at the Mat-Su VA CBOC.

Issue 5: Failure To Ensure Adequate Urology Care Following the Departure of the System's Only Urologist in 2008

We substantiated systemic problems with access to urological care following the departure of the system's only urologist.

Prior to 2007, the system contracted for urology care but in September 2007 hired a urologist who subsequently left in September 2008. Prior to departure, the urologist provided a letter to the COS identifying eight patients who needed follow-up care by a urologist. We reviewed the EHRs of all eight patients. We substantiated that one of the eight patients did not receive the recommended follow-up care by a urologist.

The patient without the appropriate follow-up had been diagnosed with a localized high grade prostate cancer. The system urologist started the patient on hormone ablation therapy. CT scans were negative for metastasis, so the system urologist consulted with VAPSHCS Urology Services to determine whether the patient could benefit from local radiation. EHR notes document that the patient received that consultation in July 2008 and was supposed to return with a decision as to whether he wanted to pursue this therapy. We could find no evidence in the EHR that the patient saw a urologist after this consultation in 2008 or 2009 or otherwise accepted or rejected this treatment option. We concluded that this patient received poor access to urology care following departure of the staff urologist.

We did not substantiate poor access for the remaining seven patients. Two of the seven patients did not have a documented need for ongoing urology care. In one of these two cases, the system denied the consult because the planned procedure was considered cosmetic, and in the second case, the patient had asked the departing urologist to order orthopedic imaging studies. Instead, this patient received an evaluation by an orthopedic surgeon within 30 days of the date of the urologist's letter to the COS.

For the remaining five patients, one patient received the recommended care by the staff urologist prior to departure, three received care by a urologist within 30 days following the date of the letter to the COS, and one received care within 60 days of the date of that letter. These timeframes complied with provider preferences for follow-up intervals as recorded in the EHR, generally accepted practices, and VHA policy.

To more thoroughly assess timely access to urological care following the urologist's departure, we reviewed consult data for the quarter immediately following the urologist's departure. During this timeframe (Quarter 1, FY 2009), 163 consults were placed for urology care outside the VA system. As mentioned earlier, this type of purchased care, when obtained through a consult process, is called Non-VA Care. Of these 163 consults, 11 were discontinued, 29 were cancelled, and 123 were completed.²⁹ Of the 123 completed Non-VA Care urology consults, 89 were completed in less than 60 days with 39 of those being completed in less than 30 days. Thirty-four of the consults took longer than 60 days to be completed.

To assess timeliness of the consults, we looked at compliance with local policy focusing on the initiating provider's requested urgency. The facility's consult policy in effect at

²⁹ Completed means that documentation has been received from the visit and the consult is completed. The consult completion date would only be the same patient visit date if the Non-VA provider submitted documentation from the visit on the day of the visit; this is not required.

the time gave the provider five options when identifying how soon he/she wanted the patient to be seen for the consult. Those options were within 24 hours, 72 hours, 1 week, 1 month, or routine—defined as within 6 months. For the 34 of the 123 (28 percent) completed Non-VA Care urology consults that took longer than 60 days, 21 of them (62 percent) met the desired urgency, and 13 did not (38 percent). Of the 13 consults that did not meet the ordering provider's desired urgency, 3 consults were delayed due to administrative processing within the system. Of those that did not meet the requested urgency, the delay was often due to a true lack of access to care. We therefore substantiated that adequate urology services were not available to patients following the departure of the system's only urologist in 2008.

Issue 6: Other Findings

While onsite, the OIG team identified opportunities for improvement in the areas discussed below that were not included in the original allegations.

Peer Review

We found that basic responsibilities for peer review were not being met.

VHA Directive 2010-025, *Peer Review for Quality Management*, requires that the Peer Review Committee (PRC) report at least quarterly to the Medical Executive Committee or its equivalent. The directive also requires that the PRC provide a secondary review of a representative sample (10 per quarter) of Level 1 peer reviews; this is the minimal threshold considered sufficient to ensure the validity and reliability of the findings and to evaluate the peer review process itself.³⁰ Peer Reviews must adhere to strict timeframes of initiation and completion.

A Peer Review Activity and Trend report was provided to the PRC quarterly by the Risk Manager. However, quarterly PRC reports were only provided to the Executive Committee of the Medical Staff (ECMS) for Quarter 1 and Quarter 2 in FY 2014; this does not meet the quarterly reporting requirement. Additionally, PRC Minutes indicate that the PRC only reviewed 20 cases for all of FY 2014; a minimum of 10 per quarter is mandated by Directive.

Provider Evaluations

We found that basic responsibilities for conducting ongoing evaluation of providers were not being met.

VHA policy identifies Clinical Executives (COS and Chief Nurse Executive) as responsible for ensuring that all clinical staff are fully credentialed prior to appointment and that they maintain accurate, complete, and timely credentials. The local credentialing and privileging policy states that the system COS is responsible for maintaining the credentialing and privileging system. After initial credentialing, the

³⁰ Level 1 is the level at which the most experienced, competent practitioners would have managed the case in a similar manner.

process used to assess eligibility for the maintenance of credentials is a performance review process. This is accomplished through a Focused Professional Practice Evaluation (FPPE).³¹ Ongoing review is accomplished through an Ongoing Professional Practice Evaluation (OPPE). VHA Handbook 1100.19, *Credentialing and Privileging*, outlines set timeframes for both FPPEs and OPPEs³² and requires they be conducted by Service Chiefs, signed off by the COS, and voted on and approved by the ECMS or a designated Committee. The COS is Chair of the ECMS and the Medical Executive Board (MEB).

VHA and local policy require OPPEs to be done every 6 months. Providers' OPPEs, however, were consistently deferred and not voted on and approved by the required committees for over a year. Additionally, there is no evidence they were conducted by the service chiefs.

This deferred action impacted the review of providers from multiple services including Joint Venture-ICU; Psychology; Radiology; Rehabilitation (which includes Audiology, Nutrition and Speech Pathology); and in Surgery all of the following: Anesthesia, Gastrointestinal, General Surgery, Optometry, Ophthalmology, Orthopedics, Physician Assistants, Podiatry, Rheumatology, and Urology. Action on FPPEs was also deferred and delinquent throughout FY 2014.

In addition to being out of compliance with national and local policy, lack of provider evaluations does not afford the provider feedback on his/her medical practice. This has the potential for patient harm.

Committee Activity and Reporting

We found that reporting of activity of committees of the medical staff to the MEB was not being done as required. We found that the system's Executive Committee had met but had not finalized, signed, or approved FY 2014 minutes as required by VHA policy. In addition, no open item log had been created to identify needed actions and to track them through the Executive Committee for completion.

The system bylaws, revised in 2013, require chairpersons of the various committees of the medical staff to attend regular meetings of the MEB when necessary to report the activities and recommendations of their committees. These committees include:

- Quality Committee
- Clinical Care Committee
- Surgical Quality Committee
- Professional Standards Board

³¹ FPPEs are used for new providers, providers requesting a new privilege, and "for cause."

³² "The timeframe for ongoing monitoring is to be defined locally. It is suggested that, at a minimum, Service Chiefs must be able to demonstrate that relevant practitioner data on a regular basis (that is, at a minimum of every 6 months)." VHA Handbook 1100.19, page 44.

- Pharmacy and Therapeutics Committee
- Peer Review Committee
- Morbidity and Mortality Committee
- Infection Control Committee
- Medical Records Committee
- Mental Health Executive Council

Organizational bylaws stipulate that all committees of the medical staff will submit minutes of all meetings to the MEB in a timely fashion and will submit other reports and documents, such as quarterly and annual reports, as required or requested. A review of FY 2014 MEB minutes showed a lack of committee oversight with infrequent to non-existent reporting as well as no evidence of medical staff committee minutes being submitted as required.

VHA Directive 1026, *Enterprise Framework for Quality, Safety and Value*, outlines the need for “an organizational structure that promotes the exchange and flow of quality information.”³³ Specifically, it states that the medical facility (or system) director must “establish a standing committee under an enterprise framework to review data, information, and risk intelligence and ensure that key quality, safety, and value functions are discussed and integrated on a regular basis.”³⁴ Additionally the directive requires the facility to:

Ensure documents generated by an Enterprise Framework for Quality, Safety, and Value activity, including meeting minutes of the standing committee, are produced in the process of conducting systematic health care reviews for the purpose of improving the quality of health care or the utilization of health care resources in VA health care facilities. Meeting minutes must record attendance and track issues to resolution.

FY 2014 minutes for the system’s Executive Committee were reviewed. Issues had not been tracked to resolution nor did any of the 12 sets of minutes contain documentation of routing or final signature. This did not come to the facility’s attention until the OIG asked for this information in the course of this review. The FY 2014 monthly Executive Committee minutes were signed on February 12, 2015, in response to the OIG’s request for these minutes. As a result of the OIG’s inquiry, the leadership team conducted a comprehensive review of the minutes noting items requiring redress. A new process was instituted to ensure minutes are routed, signed, and filed correctly and that open items requiring action are addressed.

JC also recognizes that patient safety and quality of care is incumbent upon the open flow of information and ongoing communication. JC requires that the organization use

³³ VHA Directive 1026, Enterprise Framework for Quality, Value, and Safety, August 2, 2013, p. 7.

³⁴ VHA Directive 1026, Enterprise Framework for Quality, Value, and Safety, August 2, 2013, p. 9.

data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

When data and information is unavailable to guide the decisions and processes needed to ensure a safe environment, quality of patient care is compromised.

Management Effectiveness

We found that management did not have systems in place, nor did it adhere with accountability and internal controls set forth in VHA Directive 1026, *Enterprise Framework for Quality, Safety and Value*, to carry out responsibilities necessary for the assurance of patient safety and quality of care.

JC requires that the governing body, senior managers, and leaders of the organized medical staff have the knowledge needed for their roles in the hospital. As mentioned above, VHA outlines an “Enterprise Framework for Quality, Safety and Value” in Directive 1026. A key component of the framework is that designated leaders are directly accountable for program integration and communication within their level of responsibility. The medical facility (or system) Director is responsible for ensuring that functions of the framework are in compliance with VHA standards, policies, and regulations and are integrated under an organizational structure that promotes the exchange and flow of quality information and guards against organizational silos.

The facility’s lack of adherence to VHA standards for peer review, credentialing and privileging, and program integration and communication (committee reporting) has potential for compromising patient safety and quality of care. Moreover, the issues with peer review and privileging/provider performance evaluations are repeat OIG findings. The 2008 and 2013 OIG Combined Assessment Program (CAP) reviews identified issues with how peer reviews were conducted. Similarly, the 2008 and 2011 OIG CAP reviews identified issues with provider privileges and performance data/review for reprivileging.

Culture and Morale within the System

We found that a culture of patient safety and employee morale conducive to an environment of quality of care was lacking.

In the course of data review and interviews, we identified areas of concern that if not addressed may impact not only veteran access but also patient safety. These areas include management structure and style, personnel practices, and staff morale. Per JC, governance is ultimately accountable for the safety and quality of care, and leaders must create and maintain a culture of safety and quality throughout the organization. Additionally, VHA policy outlines leadership’s responsibility:

“... to create and nurture an environment of transparency, and a just culture in which employees are mindful of inherent risks within their surroundings, and are empowered to bring concerns forth to leadership, confident that they will be addressed without fear of reprisal.”

Repeatedly, we heard about Mat-Su VA CBOC distrust of management and lack of guidance/support from leadership as well as a communication disconnect amongst and between medical staff throughout the system and clinical leadership. We heard of a lack of transparency, a schism between CBOC and parent facility staff, and for staff at the Mat-Su VA CBOC there existed a lack of responsiveness, perceived or real, from system leaders as well as concerns of being viewed as difficult to work with and having the clinic closed. Human Resources was described as a “huge barrier” in multiple conversations with both Anchorage and CBOC staff and managers. The slowness and dysfunction of personnel processes was cited as a contributing factor to recruitment and retention challenges and a major contributor to poor morale.

We looked at two surveys to see if they supported what we heard in interviews. The first, the All Employee Survey (AES), is conducted by VHA annually. It is a voluntary survey and asks questions in the areas of job satisfaction, organizational assessment, civility, and culture. We reviewed the most recent (2014) AES scores for the system, and the results indicated over a 50 percent response rate by employees. The data, however, was not specific enough to either confirm or contradict what we heard in onsite interviews with staff.

We also looked at information from the 2013 Employee Assessment Review (EAR) survey. To gather information from system employees, prior to conducting CAP reviews, the OIG administers this survey to all staff—paid and volunteer—to assess employee views regarding patient care and working conditions. The EAR was last conducted at the system in 2013 prior to that year’s OIG CAP review. Results of this most recent EAR survey mirror comments the OIG heard during onsite interviews, most notably regarding Human Resources Management Service (“Actions take months that should take days to weeks”), access issues for patients (waiting lists to be seen, delays in getting appointments), patients being treated without being seen by a doctor, overworked providers, a lack of communication, and management ineffectiveness. The survey provided employees the opportunity to comment in addition to answer questions. Concerns expressed by employees included poor morale, understaffing, lack of leadership support, turnover due to operational issues, stress and negativity, management ineffectiveness, and a hostile work environment.

Conclusions

We substantiated the allegation that provider workload and staffing negatively impacted access to care at the Mat-Su VA CBOC for the patients reviewed. We further substantiated that the Mat-Su VA CBOC lacked a permanent provider from May to October 2014.

We substantiated that decreased and delayed access resulted in quality of care issues. Patient care was compromised by a lack of communication, care coordination, and follow-up, in addition to outright delays in the provision of care.

We did not substantiate the allegation that since its opening, the Mat-Su VA CBOC has been plagued by security issues.

We substantiated the allegation that the facility did not comply with VHA scheduling directives in 2008. However we did not find evidence of current scheduling irregularities.

We substantiated the allegation that adequate urology services were not available to patients following the departure of the system's only urologist in 2008.

In addition, we found organizational structure and processes lacking, particularly in areas under the domain of clinical leadership. Insufficient processes in peer review, provider evaluation, and committee activity and reporting have the potential to compromise patient safety, as do issues of culture and morale.

Recommendations

1. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement an action plan based on ongoing monitoring of access performance measures that includes recruitment and retention, and ensure continued provision of primary care by a permanent provider at the Mat-Su VA Community Based Outpatient Clinic.
2. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events, as required by Veterans Health Administration policy.
3. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement the requirements of Veterans Health Administration Handbook 1101.10, *Patient-Aligned Care Teams*, regarding care coordination.
4. We recommended that the Veterans Integrated Service Network Director ensure that the System Director provide access to care at the Mat-Su VA Community Based Outpatient Clinic in accordance with Veterans Health Administration policy and provider recommendations for follow-up.
5. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement a peer review process consistent with Veterans Health Administration policy.
6. We recommended that the Veterans Integrated Service Network Director ensure the System Director perform peer review and consult regional counsel as appropriate for the cases identified in this report.
7. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement a provider evaluation process consistent with Veterans Health Administration policy.

- 8.** We recommended that the Veterans Integrated Service Network Director ensure that the System Director strengthen processes for committee reporting to align with Veterans Health Administration Directive 1026, *Enterprise Framework for Quality, Safety, and Value*, and system bylaws.

- 9.** We recommended that the Veterans Integrated Service Network Director ensure that the System Director assess the culture, morale, and leadership issues identified in this report, and take appropriate action as necessary.

Provider Staffing at Mat-Su VA CBOC

Providers listed below are *in addition* to Provider 1 for July 2012–April 2014

2012

July	4 days coverage from Fairbanks CBOC NP; 2 days no provider
Aug	1 day no provider
Sept	1 day no provider
Oct	Fairbanks CBOC NP; 1 day no provider
Nov	Fairbanks CBOC NP; 1 day no provider
Dec	4 days coverage from Fairbanks CBOC NP; 9 days no provider

2013

Jan	2 days coverage from Fairbanks CBOC NP; 2 days no provider
Feb	5 days coverage from Juneau Outreach Clinic Physician
Mar	6 days no provider
April	2 days no provider
May	5 days coverage by Locum Tenens Provider; 5 days no provider
June	Locum Tenens Provider
July	Locum Tenens Provider; 7 days coverage from Fairbanks CBOC NP while Provider 1 gone; 1 day no provider
Aug	Locum Tenens Provider; 5 days no provider
Sept	1 day no provider
Oct	1 day no provider
Nov	2 days coverage from Anchorage physician; 2 days no provider
Dec	2 days coverage from Fairbanks CBOC NP; 4 days no provider

2014

Jan	2 days coverage from Fairbanks CBOC NP; 5 days no provider
Feb	4 days no provider
Mar	3 days no provider
April	6 days contract physician; 1 day no provider
May	coverage by 3 contract physicians
June	coverage provided by 3 contract physicians
July	coverage provided by 2 contract physicians; 1 day no provider
Aug	coverage provided by 1 contract physician; 1 day coverage by Fairbanks CBOC NP; 1 day no provider
Sept	NP from Anchorage; 4 days no provider
Oct	NP from Anchorage; 8 days contract physician; 1 day no provider
Nov	NP from Anchorage and 1 contract physician; 2 days with additional NP from Anchorage; 2 days with no provider
Dec	NP from Anchorage and 1 contract physician

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 17, 2015
From: Director, Northwest Health Network (10N20)
Subj: Healthcare Inspection—Scheduling, Staffing, and Quality of Care Concerns, Alaska VA Healthcare System, Anchorage, Alaska
To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Thank you for the opportunity to provide responses to the findings from the Healthcare Inspection – Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska.
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.



Lawrence H. Carroll

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 10, 2015

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

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

To: Director, Northwest Health Network (10N20)

1. I have reviewed the draft report of the Inspector General's Healthcare Inspection of the Alaska VA Healthcare System. There were nine (9) recommendations.
2. I concurred with all of the recommendations, and we have completed or are in the process of completing actions to resolve the issues.


SUSAN M. YEAGER, MS
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement an action plan based on ongoing monitoring of access performance measures that includes recruitment and retention, and ensure continued provision of primary care by a permanent provider at the Mat-Su VA Community Based Outpatient Clinic.

Concur

Target date for completion: August 31, 2015

System response: We have a permanent provider at the Mat-Su VA CBOC. Access performance measures are monitored at the service and executive levels and are reported monthly at Quality Committee and Executive Committee meetings. As of April 6, 2015 demand for new patient primary care appointments is being met within 14 days of the preferred date 95% of the time. For the Mat-Su CBOC specifically, for the same timeframe, demand for new patient primary appointments is being met within 14 days of the preferred date 100% of the time, and demand for established patient primary care appointments is being met within 14 days of the preferred date 93%.

Due to the extreme difficulty in attracting and retaining qualified candidates to our remote care sites (Mat-Su CBOC, Fairbanks CBOC, Kenai CBOC, and Juneau Outreach Clinic), we have requested approval of local facility authority for recruitment, relocation, and retention incentives up to 25% of annual pay, and local authority to approve guaranteed home buyouts for physicians at those sites to attract qualified applicants. We already offer relocation benefits for provider vacancies.

Recommendation 2. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events, as required by Veterans Health Administration policy.

Concur

Target date for completion: August 31, 2015

System response: A detailed/written plan will be developed no later than May 31, 2015, to ensure appropriate documentation exists to support continuity of care and access during staff shortages.

Recommendation 3. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement the requirements of Veterans Health Administration Handbook 1101.10, Patient-Aligned Care Teams, regarding care coordination.

Concur

Target date for completion: December 31, 2015

System response: A standardized training program was created by VISN 20 with each site sending a teamlet for training in December 2014. Training on roles for staff at the Mat-Su CBOC will occur April 27 and 28, 2015. The three main aspects of the training are: patient centered care, access, and care coordination, using a standardized lesson plan from VISN 20. In addition, the RN Care Management Tool to track high risk patients in need of follow up was deployed to Mat-Su CBOC staff in February 2015.

Recommendation 4. We recommended that the Veterans Integrated Service Network Director ensure that the System Director provide access to care at the Mat-Su VA Community Based Outpatient Clinic in accordance with Veterans Health Administration policy and provider recommendations for follow-up.

Concur

Target date for completion: August 31, 2015

System response: We have had a permanent provider at the Mat-Su CBOC since September 2014. When this permanently assigned primary care provider is out of the clinic, there will be a surrogate provider assigned to cover the panel of patients. In addition to the surrogate provider, the patients will also be managed by their Patient Aligned Care Team (PACT). Refresher PACT team training is being conducted with the Matsu CBOC staff on April 27-28, 2015, to ensure that the PACT team staff at Mat-Su are familiar with the PACT process and procedures.

Recommendation 5. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement a peer review process consistent with Veterans Health Administration policy.

Concur

Target date for completion: August 31, 2015

System response: Alaska VA Healthcare System will implement corrective actions to ensure compliance with VHA Directive 2010-025. The process will be monitored to ensure compliance.

Recommendation 6. We recommended that the Veterans Integrated Service Network Director ensure the System Director perform peer review and consult regional counsel as appropriate for the cases identified in this report.

Concur

Target date for completion: August 31, 2015

System response: We are processing the nine cases referenced in this report for Protected Peer Review for Quality Management through external review (Lumetra) and we will address findings upon completion of review.

Recommendation 7. We recommended that the Veterans Integrated Service Network Director ensure that the System Director implement a provider evaluation process consistent with Veterans Health Administration policy.

Concur

Target date for completion: December 31, 2015

System response: We are implementing the provider evaluation process in accordance with Handbook 1100.19. The process will be monitored to ensure compliance.

Recommendation 8. We recommended that the Veterans Integrated Service Network Director ensure that the System Director strengthen processes for committee reporting to align with Veterans Health Administration Directive 1026, Enterprise Framework for Quality, Safety, and Value, and system bylaws.

Concur

Target date for completion: December 31, 2015

System response: An organizational review of committee meeting minutes, system bylaws and Veterans Health Administration Directive 1026, Enterprise Framework for Quality, Safety, and Value was accomplished. To correct reporting and documentation issues, the facility policy for managing committee meeting minutes was revised and is currently being routed for approval. Staff training is underway to introduce changes and expectations. Full implementation will occur once the updated facility policy is posted. Quarterly audits will be initiated to ensure compliance and sustainment of corrective actions.

Our corrective actions for our Medical Executive Board (MEB) minutes include: updating our system bylaws, correcting the agenda and adhering to reporting requirements.

Recommendation 9. We recommended that the Veterans Integrated Service Network Director ensure that the System Director assess the culture, morale, and leadership issues identified in this report, and take appropriate action as necessary.

Concur

Target date for completion: December 31, 2015

System response: The AVAHS moved forward with a departmental reorganization initiative of primary care in April of 2014, to address span of control and communication issues. The organization sought to place greater emphasis on access and standardization. A new, permanent nurse manager was hired in November 2014 at the Mat-Su clinic.

An Associate Chief Nurse for Primary Care (ACN PC) was hired in February 2015 to further drive the standardization and consistency across the system. The ACN PC conducted numerous visits to the CBOCs and outreach clinics.

We coordinated with the Union president to have National Center for Organizational Development (NCOD), visit the Mat-Su Clinic and assist with some of the ongoing morale issues. We anticipate the site visit will occur prior to August 31, 2015.

We are a pilot site for VHA Voices. We have trained 30% of its staff in VA core concepts. The purpose of VHA Voices is to learn how we connect with others; how we relate; how past experiences affect our responses and stresses; and the importance of our “story”. Training AVAHS staff on refining interviewing skills so we can hire the right people with the right attitudes and the right skills is part of the contract for VHA Voices. This training will occur no later than September, 2015.

In our ongoing effort to improve the efficiency and effectiveness of our HRMS department, we contracted with the Jefferson Group to perform a top to bottom review of our HR structure and processes. The consultants have been instrumental in finding viable solutions to long and short-range needs, formulating proposals for top management consideration and assisting with the planning and execution of improvement actions that will exist on a continuing, progressive basis. In partnership with the Jefferson Group, a comprehensive supervisor training program was developed and approved by AVAHS leadership. That training will occur in May, 2015 and will be mandatory for all supervisors.

Fifty-five percent of our employees completed the AES survey in 2014. Although results specific to the Mat-Su clinic were unattainable (less than ten people responded), key findings identified by NCOD showed Alaska HC System most improved from 2013 to 2014 in the areas of conflict resolution, safety climate, safety resources, and customer satisfaction. Scores for Safety Climate were 4.08 out of 5.0, with the National average at 3.84.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Mary Noel Rees, MPA, Team Leader Phillip Becker, MS Andrea Buck, MD Lin Clegg, PhD Sami O'Neill, MA Patrick Smith, M. Stat Susan Tostenrude, MS Marc Lainhart, BS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Northwest Health Network (10N20)
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 on our web site at www.va.gov/oig.