US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Alaska VA Healthcare System in Anchorage

Healthcare Facility Inspection	25-00248-162	August 5, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the Alaska VA Healthcare System (the facility) from August 5 through 7, 2025. The facility is rated as *low complexity* and in fiscal year 2025, provided direct care to about 26,800 unique patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

Overall, the OIG inspection did not reveal issues that warranted recommendations for corrective action in any of the five domains.

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3]
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness, or recently incarcerated.

[1] VHA classifies facilities based on their complexity level. Low-complexity facilities have "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VHA, *Facility Trip Pack: (VISN 20) Colonel Mary Louise Rasmuson Campus of the Alaska VA Healthcare System*, last updated February 24, 2026.

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

What the OIG Recommended

The OIG did not make any recommendations.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes B and C). No further action is required.

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Assistant Inspector General
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Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[4] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[5]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[6]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[7]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[8]

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[4] "VHA, About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[5] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

[6] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[7] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[8] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report.*

The Alaska VA Healthcare System (the facility) first began operating as an outpatient clinic in 1992. The facility has 35 domiciliary and 24 compensated work therapy beds, as well as five community-based outpatient clinics.[9] Its fiscal year (FY) 2025 budget was approximately $536 million.[10]

Figure 1. *Facility photo.*
Source: Photo taken by OIG inspector.

The OIG team inspected the facility from August 5 through 7, 2025. The executive leaders referred to throughout this report include the Medical Center Director (Director), Associate Director, Chief of Staff, and Associate Director for Patient Care Services. The Associate Director for Patient Care Services was the newest team member and had been in the role since March 2025.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[11] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

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[9] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/dchv. Compensated work therapy "provides evidence based and evidence informed vocational rehabilitation services" for veterans as well as other supports and partnerships for employment. "Compensated Work Therapy," VA, last updated June 15, 2026, https://department.va.gov/vha/cwt.

[10] VHA, *Facility Trip Pack: (VISN [Veterans Integrated Service Network] 20) Colonel Mary Louise Rasmuson Campus of the Alaska VA Healthcare System*, last updated February 24, 2026.

[11] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

[12] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[13] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

System Shocks

In response to an OIG questionnaire, a facility leader described executive orders and presidential memorandums that occurred in early 2025, including the return to in-person work mandate, deferred resignation program, and hiring freeze (in effect from January 20, 2025, to January 13, 2026), as system shocks that disrupted operations and increased employee stress.[14] According to the leader, these actions created a climate of uncertainty that contributed to voluntary departures.

In an interview, the Director noted that employees expressed worry and unease about these actions. In response, executive leaders disseminated available information through town halls and in-person visits to work areas. The Associate Director reported requesting hiring exemptions for positions not already excluded from the federal hiring freeze. A dedicated facility intranet page provided updates on the hiring freeze and a list of exempted positions to clarify staffing options and reduce confusion.

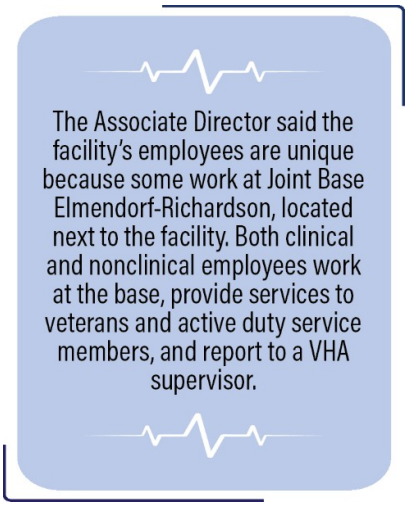

Figure 2. *Unique employee work environment and organizational structure.*
Source: OIG interview with the Associate Director.

Executive leaders reported that several applicants, including primary care and mental health providers, declined job offers and cited concerns about job stability and the broader implications of federal workforce policies. The Director said the vacancies caused providers who remained to take on additional responsibilities. Also, resignations in the veteran experience office strained facility operations due to its small number of employees.

To address some clinical position vacancies, the Director explained that executive and facility leaders leveraged the Veterans Integrated Service Network (VISN) Clinical Resource Hub, a

[14] Facility leaders referred to throughout this report can include coordinators, service chiefs, and department or program managers. Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025). VHA placed full-time employees who accepted the deferred resignation program into paid administrative leave until September 30, 2025, unless they were eligible to retire earlier. Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 28, 2025. Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025; Under Secretary for Health (10), "Removal of Hiring Freeze Restrictions for VISNs that Achieve Position Threshold Allocation (VIEWS 14237054)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), January 13, 2026.

regional program that supports care through virtual and in-person visits.[15] The Director stated the hub helped employees maintain same-day access for veterans, particularly in areas affected by staffing gaps.

In addition to clinical staffing challenges, executive leaders identified the upcoming implementation of the federal electronic health record system in October 2026, the facility's third attempt to adopt it after VHA paused implementation in April 2023, as a system shock.[16] VISN leaders conducted multiple site visits, reviewed readiness activities to support the effort, and conferred with leaders at those facilities that had already implemented the new system. Facility leaders shared with the inspection team that meeting VHA's Electronic Health Record Training Resource Center's recommendation of one super user (a trained employee who serves as a resource for colleagues in using the system) for every 10 employees, was another staffing challenge they face.[17]

The Director reported that leaders were unable to proactively recruit staff to support the implementation because of the hiring freeze. The facility's small size further limited its capacity to appoint and train the necessary number of super users without compromising essential services. To address these issues, leaders compiled a list of staffing needs, informed by both internal analyses and lessons learned from other facilities. They planned to submit a hiring waiver to VHA for positions not included on the exemption list.

In a June 2026 update, an executive leader said that, overall, the hiring issues have improved, and the facility was approved to fill additional positions related to the federal electronic health record system deployment.

Employee Experiences

Most respondents to the OIG questionnaire indicated they feel comfortable reporting patient or employee safety concerns. Leaders described several efforts to support a positive and safe work environment:

[15] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated July 28, 2025, https://department.va.gov/visn. In December 2025, VA announced plans to reorganize and consolidate its VISNs from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise. "Clinical Resource Hubs (CRH)," VA, accessed March 26, 2025, https://www.patientcare.va.gov/crh.

[16] VA, "VA Names Nine Additional Facilities that Will Deploy Federal EHR [Electronic Health Record] in 2026," news release, March 31, 2025, https://news.va.gov/press-room/nine-additional-facilities-deploy-federal-ehr-in-2026.

[17] "Frequently Asked Questions: EHR Training," Electronic Health Record Training Resource Center, https://dvagov.sharepoint.com/Frequently-Asked-Questions-EHR. (This web page is not publicly accessible.)

- Monthly safety forums that review initiatives such as safety drills for missing patients and recognize employees through the Good Catch award (for those who report safety concerns)
- Employee of the quarter and year awards, displayed in a common area
- A dedicated intranet page for employee recognition and peer nominations
- Public acknowledgment of individual accomplishments in work areas[18]

During an interview, executive leaders identified several actions they took to ensure transparent communication, such as emails (called the *Alaska Daily Digest*) to all employees that include the operating status of facility services, and weekly virtual meetings between executive leaders and community-based outpatient clinic teams.

However, employees told the OIG team that executive leaders did not visit the primary care clinic. When asked about the lack of visits, the Associate Director for Patient Care Services said leaders had recently begun to prioritize these visits.

Veteran Experiences

In response to an OIG questionnaire, a patient advocate reported that one of veterans' most common complaints was with the beneficiary travel department, which reimburses veterans' travel costs.[19] The OIG reviewed department data and found the number of unprocessed travel claim requests increased by more than six times from January 6 to July 6, 2025. Executive and facility leaders attributed the backlog to multiple employee losses, including several who departed through the deferred resignation program.

To address the backlog, executive leaders and a program manager reported that leaders hired one new employee, reassigned employees from another area to process claims, and implemented mandatory overtime in July 2025. At the time of the inspection in August 2025, the number of unprocessed claims had decreased but remained more than twice the January 6, 2025, level.

The patient advocate also said that lack of facility leader collaboration was a barrier to resolving veterans' complaints. Executive and facility leaders explained the facility's veteran experience officer left through the deferred resignation program, which disrupted coordination between leaders and employees responsible for addressing concerns. The Associate Director requested an exemption from the hiring freeze to fill the position. In the interim, the VISN veteran experience officer supported the facility by answering patient advocates' questions and strengthening

[18] Alaska VA Healthcare System, "Employee Recognition and Awards Program" (standard operating procedure), January 12, 2024.

[19] "Veterans Transportation Program (VTP)," VA, last updated May 20, 2026, https://department.va.gov/vha/vtp.

communication between the advocates and other services. The Associate Director described these efforts as positive and said the patient advocate program had improved.

Additionally, the OIG found the facility's VSignals score of 96 percent exceeded the VHA average of 94 percent in the second quarter of FY 2025, which indicates veterans have a high level of trust in the facility. The Director attributed this performance to employee dedication and outreach. For example, employees identified a 100-year-old veteran who was not enrolled in VA care and helped them register for medical services and benefits.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[20] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[21]

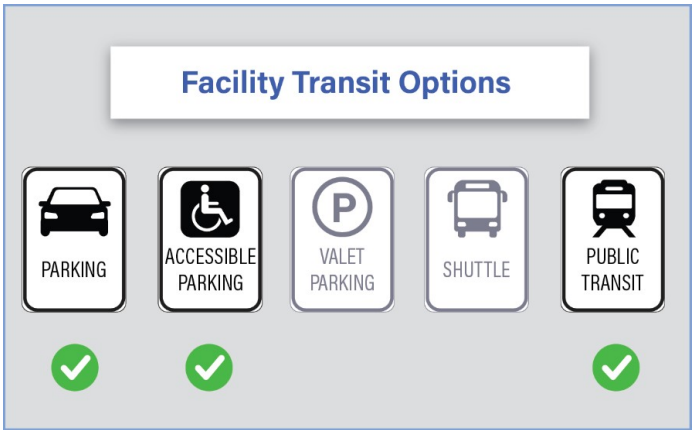

Figure 3. *Transit options for arriving at the facility. Source: Team observations, parking maps, and information submitted by the facility liaison.*

General Inspection

The facility was easy to find and navigate; it also had sufficient parking and a welcoming main entrance. The main entrance featured an overhead canopy, heated sidewalks, and detectable warning surfaces to alert visually impaired veterans of their approach to traffic. Inside there were well-lit seating areas with reading materials, and a café where veterans could socialize.

[20] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[21] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

Additionally, the lobby had wheelchairs and an information desk staffed with volunteers who helped veterans get to their appointments. Adjacent to the desk were color-coded directional maps with large fonts; printed copies were available on the desk. There were also wall-mounted maps and braille symbols on elevators and clinic doors. During physical inspections, the OIG team learned that staff offer assistive listening devices, such as personal amplifiers, to veterans upon request.

The team inspected primary and specialty care areas and found them clean and generally well-maintained. When the team noted superficial wall scratches in two primary care areas and a peeling ceiling tile in one specialty care area, staff took immediate corrective actions.

The inspection team also reviewed the facility's action in response to a recommendation from the previous OIG healthcare inspection in March 2023, which addressed temperature and humidity monitoring issues in a community-based outpatient clinic supply room.[22] In response, the chief of facilities management said leaders implemented electronic monitoring with alerts for out-of-range readings, and therefore, the OIG closed the recommendation.

However, during the current inspection in August 2025, the team observed a nonfunctioning monitoring device (due to a depleted battery) in a specialty care procedure room. The chief of facilities management said the device differed from the facility's standard models, which staff continuously monitor through a centralized system. In response, staff replaced the device with a standard model during the OIG's visit and will monitor it; thus, the OIG made no recommendation.

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* requires written processes to communicate urgent, noncritical test results and service-level workflows that describe the roles of various team members in the process.[23] The OIG team discovered that facility leaders had processes to notify providers who order tests of these results, follow up with patients, designate a replacement for providers who were unavailable or had left the facility, and

[22] VA OIG, *Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage*, Report No. 23-00017-81, February 22, 2024.

[23] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

transmit results during care transitions and outside of regular clinic hours. In addition, facility leaders explained the communication process and later provided a written copy of the service-level workflows.

Leaders indicated they monitor communication of test results through a contracted External Peer Review Program.[24] The findings show whether patients received results that require action within seven days from the time they became available, as required by VHA Directive 1088(1). Pathology and laboratory leaders report the findings to executive leaders on a quarterly basis.

Action Plans and Process Improvements

The OIG evaluated previous oversight reports and did not identify any issues related to the communication of test results, or recommendations that had been open for more than a year.[25] Facility leaders credited their success in implementing and maintaining action plans from oversight reports to diligent monitoring by the facility's Quality and Safety Council. They noted the council meets monthly to track adherence to action plans and provides quarterly reports to the Executive Leadership Board.

Facility leaders said that providers receive test results through alerts within the electronic health record system. VHA Directive 1088(1) mandates that leaders evaluate the number and types of electronic health record alerts to prevent unnecessary information burdens on providers. Facility leaders described a recent multidisciplinary project that assessed and streamlined alerts. Through the project, staff reduced the total number by 89 percent.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[26] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

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[24] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "identified deficiencies are addressed." VHA Directive 1088(1).

[25] VA OIG, *Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage*; The Joint Commission, *Final Accreditation Report Alaska VA Healthcare System-Laboratory*, May 20, 2025; The Joint Commission, *Final Accreditation Report Alaska VA Healthcare System Ambulatory*, *Behavioral Health Care and Human Services*, *Home Care*, July 6, 2022.

[26] "Community Care," VA, last updated June 16, 2026, https://department.va.gov/vha/community-care; VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

Primary Care Staffing and Access to Care

The OIG reviewed facility-provided data and found there were vacancies for six providers, four registered nurses, four licensed practical nurses, and six medical support assistants across 25 primary care teams. Primary care leaders attributed recruitment challenges to perceived uncertainty about federal employment and lengthy hiring processes.

The leaders reported they received VHA approval in June 2025 to expand provider roles to include nurse practitioners and physician assistants. At the time of the inspection in August 2025, leaders reported that provider and medical support assistant positions were in various phases of recruitment and hiring. However, a leader said it was challenging to recruit licensed practical nurses because of limited training programs in Alaska. Leaders discussed plans to expand eligibility to intermediate care technicians, a change they anticipate will attract more candidates interested in these roles. Primary care staff described the effects of vacancies on daily operations, such as increased workloads to cover vacant positions as well as long wait times for new patients.

In an interview, primary care staff reported they experienced burnout and fatigue due to large panel sizes (number of patients assigned to a care team) and heavy workloads.[27] As a temporary solution, leaders said they use a walk-in clinic for unscheduled appointments to allow timely patient access to care until they achieve adequate staffing. Leaders outlined additional mitigation strategies, including referrals to the Clinical Resource Hub, and float pool nurses (who are not assigned to a team and assist where needed).

The OIG reviewed facility data that showed new patient wait times were 32 days in quarter one of FY 2025 and decreased slightly to 28 days in quarter two. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is greater than 20 days.[28] Primary care leaders attributed these wait times to provider vacancies. The OIG acknowledged facility leaders' efforts to address staffing and did not make a recommendation.

Community Care Staffing and Access to Care

VHA's *Consult Timeliness Standard Operating Procedure* requires staff to schedule community care appointments for veterans within seven days of the referral.[29] However, community care leaders told the OIG they are unable to meet the requirement because of the high volume of referrals. Leaders also said wait times for community care providers vary depending on the type

[27] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

[28] 38 C.F.R. § 17.4040 (2025).

[29] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

of service. The leaders work closely with the third-party administrators (companies that manage the community care network) to increase access, consider provider availability concerns, and coordinate with the VISN, which provides administrative float staff to the facility. Leaders also plan to expand access to specialty care at Joint Base Elmendorf-Richardson.

Community care staff described their unique Community Care Hub, a centralized support point to coordinate care. Veterans can walk in or call the hub team to get updates on community care processes.

The OIG reviewed Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH), and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The inspection team analyzed enrollment and performance data and interviewed facility program staff.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[30]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of veterans who received an HCHV program intake assessment.[31] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional

[30] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[31] VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures,* November 2024.

residences for veterans with mental health or substance use conditions).[32] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[33] At the time of the OIG inspection in August 2025, FY 2024 was the most current complete fiscal year data available for these performance measures.

Performance and Improvement Highlights

- The facility program met the intake assessment (HCHV5) target from FY 2024 through the second quarter of 2025. Facility program staff credited their success to instant VA eligibility checks: when outreach staff encounter a veteran who was unsheltered, they immediately contact HCHV staff, who verify the veteran's eligibility status. Once staff verify eligibility, they complete an intake assessment, screen for health concerns like posttraumatic stress disorder, and refer the veteran to housing resources.
- Staff reported the HCHV program did not have contract residential services; however, they work with community partners, such as Anchorage Affordable Housing and Land Trust, to find housing options.[34] The trust has converted hotels that now provide permanent housing for veterans and others.

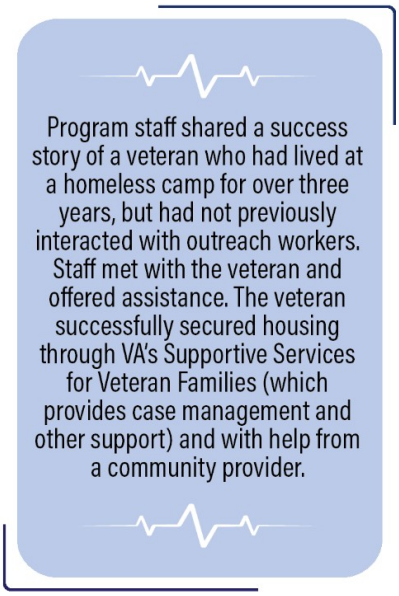

Figure 4. *Success story. Source: Questionnaire response from the HCHV chief.*

[32] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

[33] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

[34] "AAHLT [Anchorage Affordable Housing and Land Trust] strengthens the community by acquiring, managing, and preserving permanently affordable housing for low and extremely low-income residents." "About Anchorage Affordable Housing and Land Trust," Affordable Housing and Land Trust Anchorage, accessed March 13, 2026, https://aahlt.org/about.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[35] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[36]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[37]

Performance and Improvement Highlights

- The facility program did not meet the voucher use (HMLS3) target from FY 2024 through the second quarter of FY 2025. The program chief explained that vouchers assigned to remote and tribal locations kept the overall measure slightly below the target.
- The program met the employment (VASH3) target from FY 2024 through the first two quarters of FY 2025. The chief attributed the success to the employment coordinator, who builds relationships with potential employers and communicates job opportunities in the program's weekly team meeting. The coordinator also works with veterans one-on-one to match their experience to specific jobs.
- Staff identified affordable housing as an increasing concern since VHA expanded program eligibility related to military discharge status. Services are now available to veterans with other than honorable or bad conduct discharges.[38] Staff said these veterans have complex needs, such as histories of substance abuse and

The chief shared a recent milestone in which program staff received access to a homeless shelter's information system. Previously, they depended on homeless shelters to report the presence of veterans, but shelter staff sometimes did not correctly identify them. Now program staff can proactively check shelter intakes to find veterans and contact them sooner.

Figure 5. *Success story. Source: Interview with and questionnaire responses from the program chief.*

[35] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[36] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[37] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

[38] VHA Directive 1601A.02(6), *Eligibility Determination*, July 6, 2020, amended March 6, 2024.

chronic mental illness, that make it difficult to find and keep stable housing, especially when private landlords have strict requirements related to evictions or legal history.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[39] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[40]

Performance and Improvement Highlights

- The facility program did not meet the enrollment (VJP1) target for FY 2024. However, program staff said the measure does not reflect their outreach work because there is insufficient time to conduct intake assessments when they meet with veterans in correctional facilities. With limited time to meet, staff educate veterans on services and refer them for mental health care and substance abuse treatment.
- A staff member shared a success story of a veteran with a history of severe mental illness, substance abuse, arrests, and homelessness. The veteran initially declined program enrollment, but staff continued to offer services. Once the veteran became open to help through veterans treatment court, staff worked with the jail and court system to provide access to mental health and substance abuse treatment.[41] The veteran also benefited from the facility's Mental Health Residential Rehabilitative Treatment Program, which provided care, a living space, and help for substance abuse.[42] The veteran successfully transitioned into the community, secured housing, and maintained employment.

[39] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[40] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

[41] A veterans treatment court is a "long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

[42] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

Conclusion

To assist leaders in evaluating the quality of care at the Anchorage facility, the OIG conducted an inspection across five domains. Based on the overall positive findings, no recommendations for corrective action are included in this report. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[43] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The team inspected the facility from August 5 through 7, 2025. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

The team's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[44]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[45] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[46] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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[43] The accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

[44] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[45] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

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

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 24, 2026

From: VISN 5, Network Director (496/10N20)

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

To: Director, Office of Healthcare Inspections (54HF01)

Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed the draft report, Healthcare Facility Inspection of Alaska VA Healthcare System in Anchorage.
2. I concur with the report as written.

(Original signed by:)

Teresa D. Boyd, DO

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 24, 2026

From: Director, Alaska VA Healthcare System (463)

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

To: VISN 5, Network Director (496/10N20)

1. I have received and reviewed the OIG Healthcare Facility Inspection draft report for the Alaska VA Healthcare System in Anchorage.
2. Although there were no recommendations in the report, we are committed to continually improving the quality of care we provide.

(Original signed by:)

Jennifer Price, MPA
Executive Director (Acting)

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.