



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the West Texas
VA Health Care System
Big Spring, Texas



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Figure 1. West Texas VA Health Care System, Big Spring, Texas
(Source: <https://vaww.va.gov/directory/guide/>, accessed on August 16, 2019)

Abbreviations

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



Report Overview

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

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

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

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

This unannounced visit was conducted during the week of May 6, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

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

The facility’s leadership team had been working together for four months as of the OIG site visit. The chief of staff, appointed in January 2019, was the newest permanently assigned member of the team, while the director was the most tenured, having been in the position since December 2016.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders had opportunities to improve engagement and promotion of a culture of safety where employees feel safe bringing forward issues and concerns. The selected patient experience survey scores for facility leaders were lower than the VHA average, and facility leaders had implemented processes and plans to improve positive patient experiences.¹

Additionally, the OIG reviewed accreditation agency findings, sentinel events,² and disclosures of adverse patient events and did not identify substantial organizational risk factors.

The prior OIG Comprehensive Healthcare Inspection Program Review report³ had one open remaining recommendation. The chief of Quality Management provided evidence of the facility’s progress and monitoring; however, at the time of the onsite visit, there was insufficient evidence to close the recommendation.

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

¹ The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

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

³ VA Office of Inspector General, *Comprehensive Healthcare Inspection Program Review of the West Texas VA Health Care System, Big Spring, Texas*, Report No. 17-01742-90, February 5, 2018.

and differences between the top and bottom performers” within VHA.⁴ The leadership team members were generally knowledgeable within their areas of responsibility about selected SAIL metrics, and the ADPCS was knowledgeable about SAIL community living center (CLC) measures. The leaders should continue to take actions to improve performance of the quality of care metrics and measures likely contributing to the facility’s SAIL and CLC “1-star” quality ratings.⁵

The OIG noted deficiencies in six of the eight clinical areas reviewed and issued 13 recommendations that are attributable to the director and chief of staff. These are briefly described below.

Quality, Safety, and Value

The OIG found there was general compliance with requirements for protected peer reviews. However, the OIG identified concerns with completion of the minimum number of root cause analyses, submission of the annual patient safety report to facility leaders, and committee review of each resuscitation episode.

Medication Management

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the pharmacy operations, pharmacy inspections, and facility review of override reports. However, the OIG identified noncompliance with submission of monthly summary of findings and quarterly trend reports to the director, quality management committee reviews of the program reports, completion of required annual competencies, and verification of controlled substance orders.

Mental Health

Generally, the OIG team found compliance with designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and provision of clinical care. However, the OIG noted a concern with the mental health and primary care providers completing MST mandatory training.

⁴ VHA’s Office of Operational Analytics and Reporting developed a model for understanding a facility’s performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a “star rating” system to designate a facility’s performance in individual measures, domains, and overall quality.

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

⁵ Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

Geriatric Care

For geriatric patients, the OIG found compliance with providers documenting justification for initiating the medication, validating patient and/or caregiver understanding when education was provided, and reconciling the patients' medications relevant to the episode of care. However, the OIG identified inadequate patient and/or caregiver education specific to the newly prescribed medications.

Women's Health

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

High-Risk Processes

The OIG inspection revealed that the facility generally complied with many of the performance indicators used to assess the high-risk process of the operations and management of the urgent care center. However, the OIG identified noncompliance with the workload capture process, a backup call schedule for urgent care center providers, and reporting of patient data to the VHA Emergency Medicine National Program Office.

Summary

In reviewing key healthcare processes, the OIG issued 13 recommendations for improvement directed to the facility director and chief of staff. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.



Comments

The Veterans Integrated Service Network director and acting facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 64–65, and the responses within the body of the report for the full text of the directors’ comments.) The OIG considers recommendations 11–13 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

A handwritten signature in black ink that reads "John D. Daigh, Jr., M.D.".

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
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Purpose and Scope

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

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.⁶ Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.⁷ Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:⁸

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

⁶ Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>. (The website was accessed on January 24, 2019.)

⁷ Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. <http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen>. (The website was accessed on January 24, 2019.)

⁸ See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

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

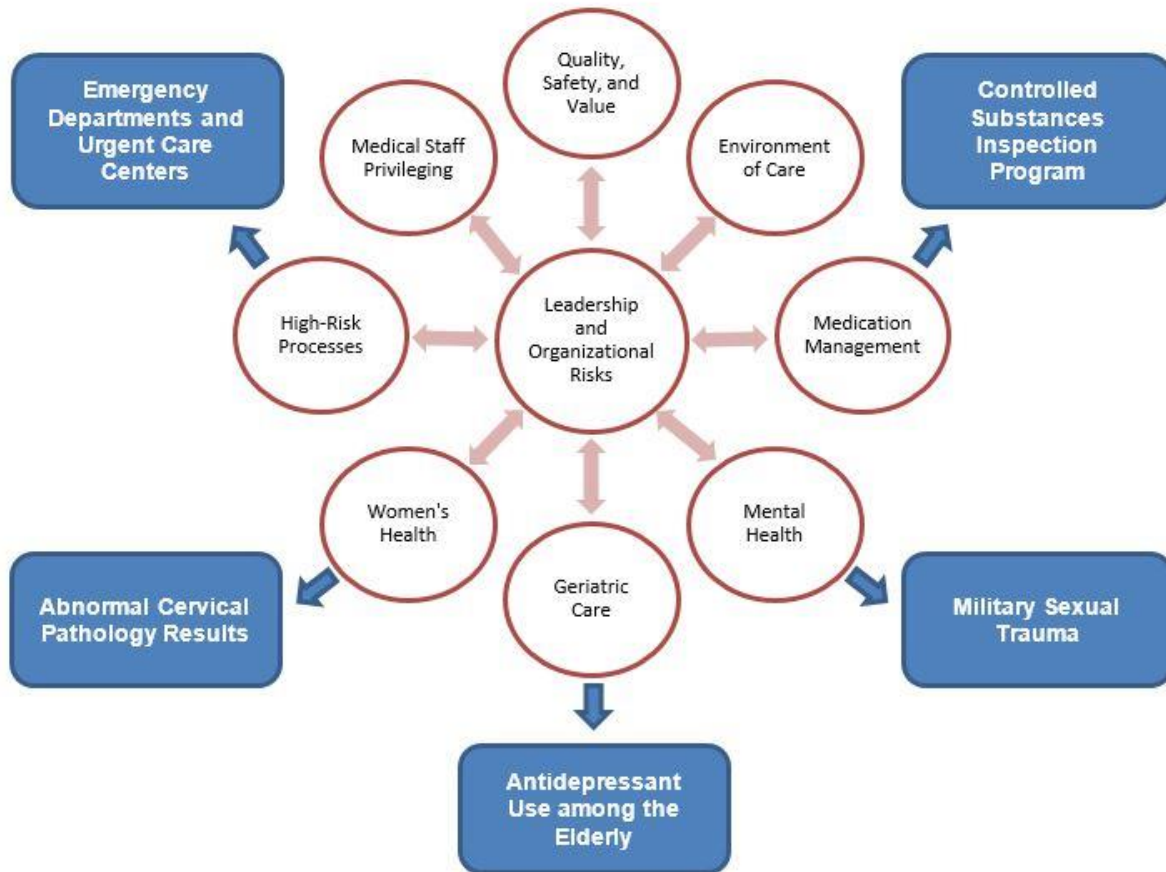


Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;⁹ physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from June 24, 2017, through May 9, 2019, the last day of the unannounced nearly week-long site visit.¹⁰ While on site, the OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation.

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

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

⁹ The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

¹⁰ The range represents the time period from the last Comprehensive Healthcare Inspection Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.¹¹ To assess the facility's risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

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

¹¹ L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

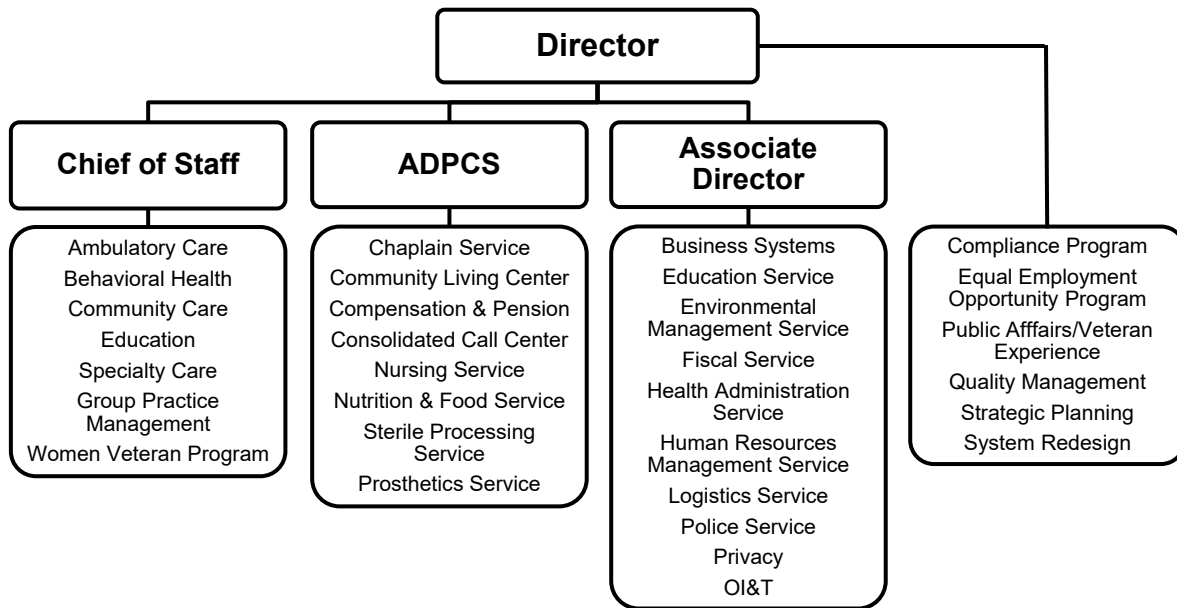


Figure 3. Facility Organizational Chart¹²

Source: West Texas VA Health Care System (received May 6, 2019)

At the time of the OIG site visit, the facility director, chief of staff, and ADPCS had been working together for four months. (See Table 1.)

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	December 11, 2016
Chief of staff	January 6, 2019
Associate director for Patient Care Services	July 23, 2017
Associate director	April 14, 2019 (Acting)

Source: West Texas VA Health Care System human resources officer (received May 6, 2019)

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

In individual interviews, the facility director, chief of staff, and ADPCS generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee satisfaction, and patient experiences. In addition, the facility director, chief of staff, and ADPCS were generally knowledgeable within their scope of

¹² At this facility, the director is responsible for the Compliance Program, Equal Employment Opportunity Program, Public Affairs/Veteran Experience, Quality Management, Strategic Planning, and System Redesign.

responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics, and the ADPCS was knowledgeable about SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chairperson of the Leadership Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Leadership Council oversees various working groups, such as the Employee Development, Integrated Ethics, Medical Executive, Nurse Executive, and Quality Executive Boards. See Figure 4.

These facility leaders are also engaged in monitoring patient safety and care through the Quality Executive Board, for which the director and chief of Quality Management are co-chairs. The Quality Executive Board is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes.

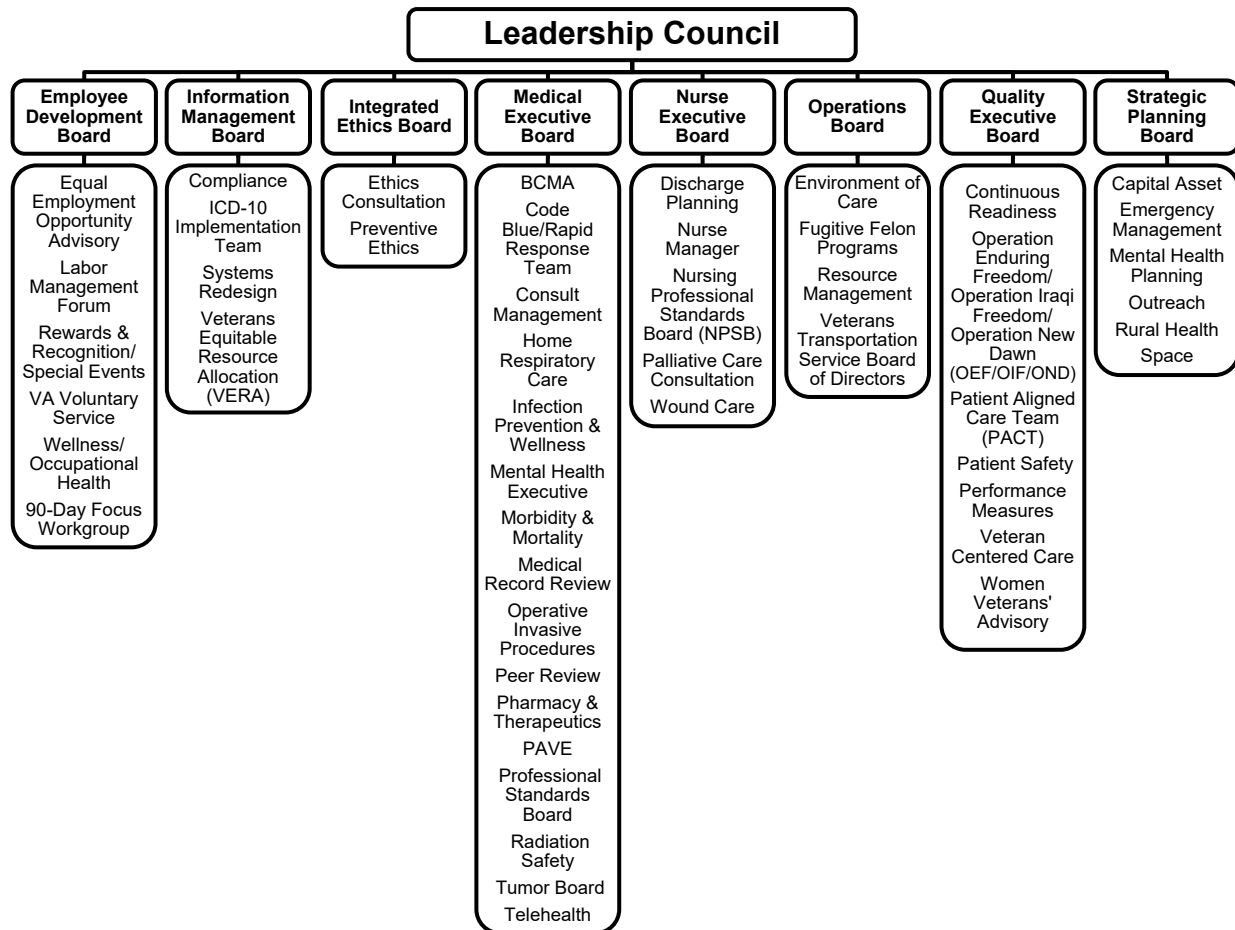


Figure 4. Facility Committee Reporting Structure

Source: West Texas VA Health Care System (received May 6, 2019)

PAVE = Prevention of Amputation in Veterans Everywhere

BCMA = Bar Code Medication Administration

ICD-10 = International Statistical Classification of Diseases and Related Health Problems, 10th revision

Employee Satisfaction

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

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA’s All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.¹³ Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA’s All Employee Survey.¹⁴ The OIG found the facility averages for the selected survey leadership questions were lower than the VHA average.¹⁵ The same trend was noted for the members of the executive leadership team. In all, opportunities exist to improve employee satisfaction with facility leaders.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i> ¹⁶	0–100 where HIGHER scores are more favorable	71.7	70.4	59.5	61.9	70.0	59.7

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

¹⁴ It is important to note that the 2018 All Employee Survey results are not reflective of employee satisfaction with the current chief of staff.

¹⁵ The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

¹⁶ According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index “is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others’ contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others’ needs before their own.”

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.1	2.9	1.9	3.2	2.6
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.2	2.9	1.8	3.3	2.9
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.3	3.0	1.9	3.2	3.1

Source: VA All Employee Survey (accessed April 4, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were generally similar to or worse than the VHA average, except for the director whose averages were similar to or better than the VHA average. In all, opportunities appear to exist for all facility leaders to improve employee satisfaction and support an environment where employees feel safe bringing forth issues and concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.3	2.6	3.8	3.5

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.7	3.8	3.7	3.3	3.7
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never) – 6 (Every Day)	1.5	1.4	1.0	3.2	1.1	2.5

Source: VA All Employee Survey (accessed April 4, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through June 30, 2018. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.¹⁷

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

¹⁷ Ratings are based on responses by patients who received care at this facility.

outpatients’ attitudes toward facility leaders (see Table 4). For this facility, the survey results reflected lower care ratings than the VHA average. Opportunities appear to exist to improve outpatient satisfaction. However, facility leaders appeared to be actively engaged with patients and community stakeholders to improve the facility ratings. For example, through a director initiative, the facility holds monthly town hall meetings where veteran service organizations are invited to attend. Additionally, nurse practitioner recruitment initiatives have been implemented to fill provider coverage gaps and give stability for care teams.

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

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.9	n/a ¹⁸
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	84.2	n/a
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.3	68.9
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.5	73.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)

¹⁸ The facility does not provide inpatient care, therefore the average for the two inpatient survey questions is not applicable (n/a).

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.¹⁹ Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).²⁰ During the on-site review, the OIG noted that the most recent Comprehensive Healthcare Inspection Program Review report had one open recommendation.²¹ The chief of Quality Management reported continued monitoring of the facility's progress and demonstrated that steps were being taken toward closing the recommendation.

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.²² Additional results included the Long Term Care Institute's inspection of the facility's CLC.²³

¹⁹ The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

²⁰ According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

²¹ A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

²² According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. <https://www.cap.org/about-the-cap>. (The website was accessed on February 20, 2019.) In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

²³ The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 external regulatory surveys since 1999. The Long Term Care Institute is "focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings." Long Term Care Institute. <http://www.ltciorg.org/about-us/>. (The website was accessed on March 6, 2019.)

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Comprehensive Healthcare Inspection Program Review of the West Texas VA Health Care System Big Spring, Texas, Report No. 17-01742-90, February 5, 2018</i>)	June 2017	11	1
TJC Accreditation	June 2017	31	0
TJC Ambulatory Health Care		6	
TJC Behavioral Health Care Accreditation		13	
TJC Home Care Accreditation		13	

Sources: OIG and TJC (inspection/survey results verified with the chief of Quality Management on May 9, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from June 24, 2017 (the prior comprehensive OIG inspection), through May 9, 2019.²⁴

²⁴ It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the West Texas VA Health Care System is a low complexity (3) affiliated facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors
(June 24, 2017, through May 9, 2019)**

Factor	Number of Occurrences
Sentinel Events ²⁵	2
Institutional Disclosures ²⁶	2
Large-Scale Disclosures ²⁷	0

Source: West Texas VA Health Care System’s chief of Quality Management (received May 9, 2019)

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to “understand the similarities and differences between the top and bottom performers” within VHA.²⁸

VA also uses a star-rating system where facilities with a “5-star” rating are performing within the top 10 percent of facilities and “1-star” facilities are performing within the bottom 10 percent of facilities. Figure 6 describes the distribution of facilities by star rating.²⁹ As of June 30, 2018, the facility was rated as “1-star” for overall quality.

²⁵ The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.”

²⁶ According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”

²⁷ According to VHA Directive 1004.08, large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.”

²⁸ VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL) Value Model*, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

²⁹ According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

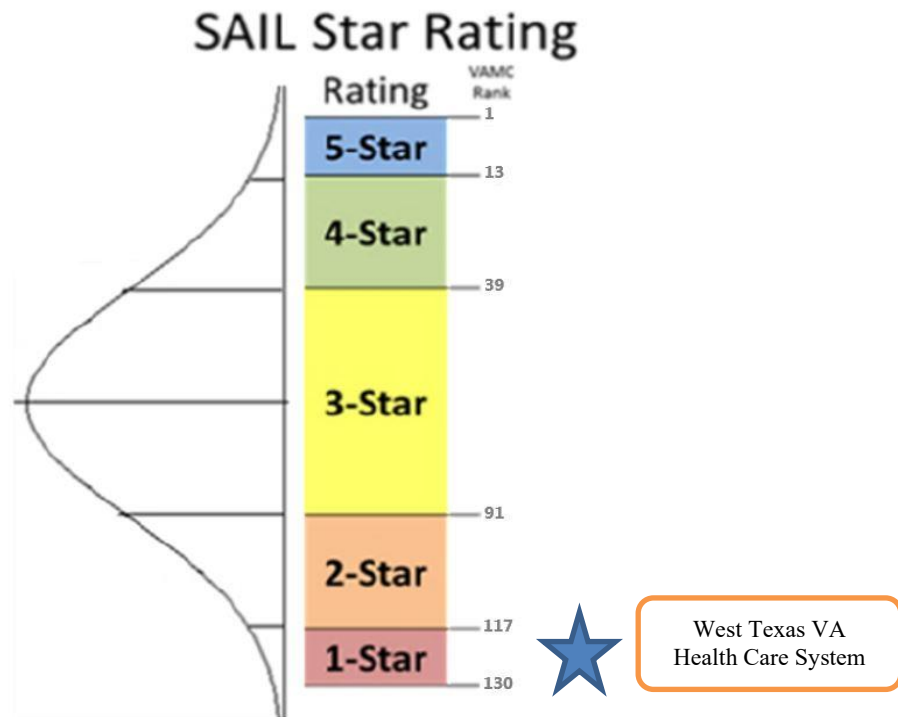
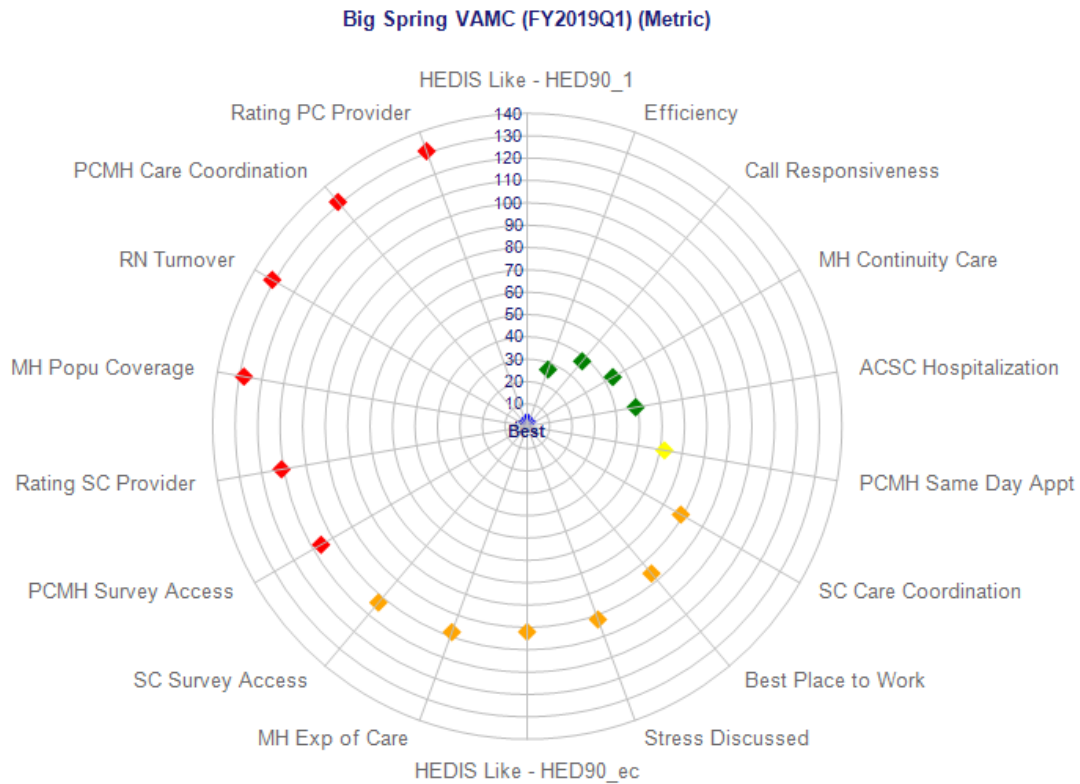


Figure 6. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed April 4, 2019)

Figure 7 illustrates the facility’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of outpatient performance measures (HEDIS Like – HED90_1), call responsiveness, and ambulatory care sensitive condition (ACSC) hospitalization). Metrics that need improvement are denoted in orange and red (for example, best place to work, rating (of) specialty care (SC) provider, registered nurse (RN) turnover, patient centered medical home (PCMH) care coordination, and rating (of) primary care (PC) provider).³⁰

³⁰ For information on the acronyms in the SAIL metrics, please see Appendix D.



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 7. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)

Source: VHA Support Service Center

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

The SAIL Value Model also includes “SAIL CLC,” which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare*.³¹ The SAIL CLC provides a single resource to review quality measures and health inspection results. It

³¹ According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

includes star ratings for an unannounced survey, staffing, quality, and overall results.³² Table 7 summarizes the rating results for the facility’s CLC as of December 31, 2018. Although the facility has an overall “4-star” rating, its rating for quality is only a “1-star.”

**Table 7. Facility CLC Star Ratings
(as of December 31, 2018)**

Domain	Star Rating
Unannounced Survey	4
Staffing	5
Quality	1
Overall	4

Source: VHA Support Service Center

In exploring the reasons for the “1-star” quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 8 illustrates the facility’s CLC quality rankings and performance compared with other VA CLCs as of December 31, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of receive antipsychotic medications—long stay (LS), ability to move independently worsened (LS), and improvement in function—short stay (SS)). Metrics that need improvement and were likely the reasons why the facility had a “1-star” for quality are denoted in orange and red (for example, new or worse pressure ulcer (PU) (SS), urinary tract infection (UTI) (LS), and moderate-severe pain (LS)).³³

³² *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019).
<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>.
(The website was accessed on September 3, 2019 but is not accessible by the public.)

³³ For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

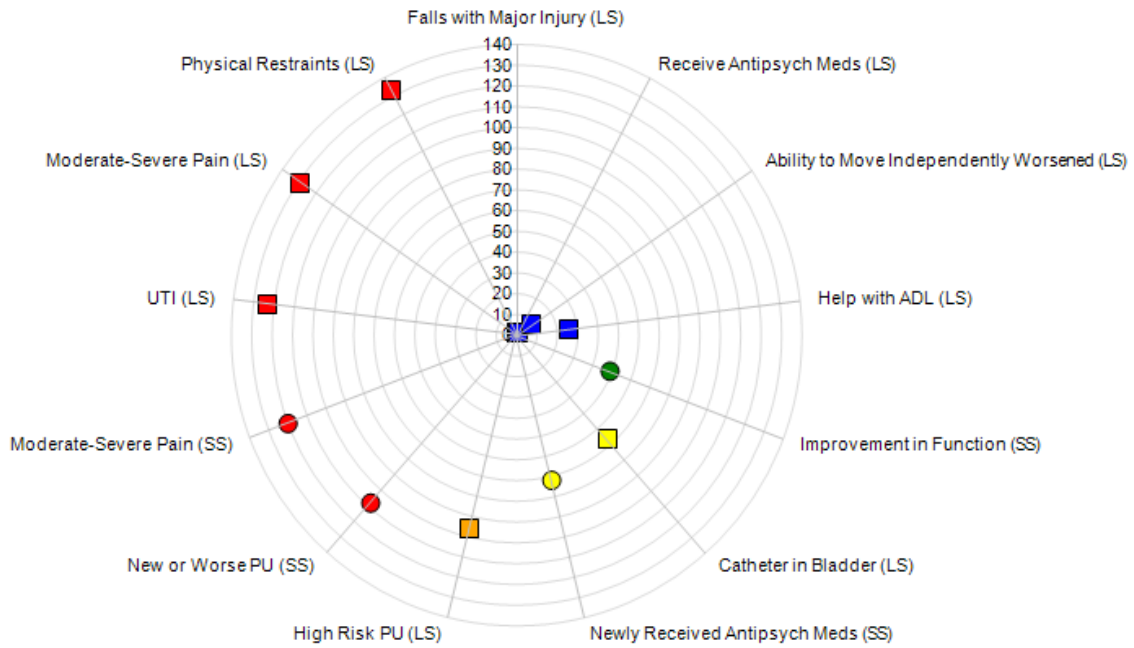


Figure 8. Facility CLC Quality Measure Rankings (as of December 31, 2018)

LS = Long-Stay Measure SS = Short-Stay Measure

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team included an acting associate director, and the chief of staff position was permanently filled less than six months prior to the OIG's on-site visit. The OIG noted that selected survey scores related to employee satisfaction and patient experiences demonstrated various opportunities for improvement. However, the facility leaders appeared actively engaged with employees and patients and were working to improve employee and patient engagement and satisfaction. The leaders seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement). The OIG's review of the facility's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The director, chief of staff, and ADPCS were knowledgeable within their scope of responsibility about selected SAIL data, and the ADPCS was knowledgeable about SAIL CLC metrics. Nonetheless, the executive leadership team should continue to take actions to improve performance of measures contributing to the SAIL and CLC "1-star" quality ratings.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.³⁴ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³⁵ VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.³⁶

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,³⁷ utilization management (UM) reviews,³⁸ patient safety incident reporting with related root cause analyses,³⁹ and cardiopulmonary resuscitation (CPR) episode reviews.⁴⁰

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.⁴¹

³⁴ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

³⁵ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³⁶ VHA Directive 1026.

³⁷ The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

³⁸ According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019) UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

³⁹ The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

⁴⁰ VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

⁴¹ VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.⁴²

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.⁴³

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.⁴⁴

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:⁴⁵

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

⁴² VHA Directive 1117(2).

⁴³ VHA Handbook 1050.01.

⁴⁴ VHA Directive 1177; VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

⁴⁵ For CHIP inspections, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit⁴⁶
- UM⁴⁷
 - Completion of at least 75 percent of all required inpatient reviews
 - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
 - Interdisciplinary review of UM data
- Patient safety
 - Annual completion of a minimum of eight root cause analyses⁴⁸
 - Inclusion of required content in root cause analyses (generally)
 - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
 - Provision of feedback about root cause analysis actions to reporting employees
 - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
 - Evidence of a committee responsible for reviewing resuscitation episodes
 - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
 - Evidence of basic or advanced cardiac life support certification for code team responders
 - Evaluation of each resuscitation episode by the CPR Committee or equivalent

Quality, Safety, Value Conclusion

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

⁴⁶ VHA Directive 1190.

⁴⁷ The facility does not provide inpatient care.

⁴⁸ According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analyses per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

submitting the annual patient safety report to facility leaders, and CPR Committee review of each resuscitation episode that warranted recommendations for improvement.

Specifically, VHA requires facilities to annually complete a minimum of eight root cause analyses to help identify and mitigate vulnerabilities in their systems of care and to also avoid future occurrences.⁴⁹ For FY 2018, the chief of Quality Management reported that the facility completed seven of the eight required root cause analyses, limiting opportunities for the facility to identify and improve system vulnerabilities.⁵⁰ The chief of Quality Management reported the patient safety manager position was vacant and therefore lack of oversight was the reason for noncompliance. Additionally, Quality Management staff evaluated incidents for possible root cause analysis, however, the chief of Quality Management reported no trends were identified to necessitate an additional (eighth) root cause analysis.

Recommendation 1

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

Facility concurred.

Target date for completion: December 27, 2019

Facility response: A minimum of eight (8) root cause analyses (RCAs) were completed for FY 2019. The Facility Director will monitor number of RCA's reported by the Patient Safety Manager (PSM) monthly until a sustained and maintained reporting compliance of 90% is achieved to ensure the organization is on track to complete the 8 RCA's within the required time period.

VHA requires that facility leaders review a Patient Safety Annual Report at the end of the fiscal year.⁵¹ Facility staff could not provide evidence that executive leaders had reviewed the Patient Safety Annual Report for FY 2018. This resulted in an insufficient evaluation of the patient safety program and limited potential leadership oversight and interventions for system vulnerabilities. The chief of Quality Management reported the patient safety manager position was vacant and, therefore, cited lack of oversight as the reason for noncompliance.

Recommendation 2

2. The facility director ensures that facility leaders review a Patient Safety Annual Report at the end of the fiscal year and monitors the patient safety manager's compliance.

⁴⁹ VHA Handbook 1050.01.

⁵⁰ VHA Handbook 1050.01.

⁵¹ VHA Handbook 1050.01.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The Facility Director and facility leadership reviewed the Annual Patient Safety Report for FY 2019 in Leadership Council. The Facility Director will monitor for sustained compliance by adding the Patient Safety Manager's Annual Patient Safety Report to the agenda for Leadership Council review at beginning of each fiscal year.

In accordance with The Joint Commission (TJC) standards, VHA requires that the facility Cardiopulmonary Resuscitative (CPR) Committee (referred to as the Code Blue/Rapid Response Team (RRT) Committee at this facility) reviews each resuscitative episode of care.⁵² The Code Blue/RRT Committee chair reported there were no resuscitative episodes from May 1, 2018, through May 1, 2019. However, during the OIG site visit, Quality Management staff identified two resuscitative episodes that occurred between May 6, 2018, and May 6, 2019. The OIG did not find evidence that the Code Blue/RRT Committee reviewed the two resuscitative episode events. This resulted in potential missed opportunities for the identification of errors or deficiencies in technique or procedures, equipment availability or malfunction, and clinical issues or patient care issues, such as failure to rescue. The chief of staff and associate chief of staff stated there was no consistent process in place to ensure all resuscitation episodes are communicated to the Code Blue/RRT Committee for review.

Recommendation 3

3. The chief of staff ensures that the Code Blue/Rapid Response Team Committee reviews each resuscitative episode and monitors committee compliance.

Facility concurred.

Target date for completion: April 1, 2020

Facility response: The chief of staff will revise the local Code Blue/Rapid Response Team Committee Charter Health Care System Memorandum (HCSM) to include a review of 100% resuscitative events by the Code Blue/RRT Committee. The Chief of Staff will ensure Code Blue/RRT Committee report reviews are submitted to the Medical Executive Board until a 90% sustained compliance is achieved for 6 months.

⁵² VHA Directive 1177.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all healthcare professionals who are permitted by law and the facility to practice independently”—“without supervision or direction, within the scope of the individual’s license, and in accordance with individually granted clinical privileges.” These healthcare professionals are also referred to as licensed independent practitioners (LIPs).⁵³

Clinical privileges need to be specific, based on the individual’s clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.⁵⁴

VHA defines the focused professional practice evaluation (FPPE) as “a time-limited period during which the medical staff leadership evaluates and determines the practitioner’s professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges.” “The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPE), is essential to confirm the quality of care delivered.”⁵⁵

According to TJC, the “FPPE for Cause” should be used when a question arises regarding a privileged provider’s ability to deliver safe, high-quality patient care. The “FPPE for Cause” is limited to a particular time frame and customized to the specific provider and related clinical concerns.⁵⁶ Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.⁵⁷

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

⁵³ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

⁵⁴ VHA Handbook 1100.19.

⁵⁵ VHA Handbook 1100.19.

⁵⁶ Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2).

⁵⁷ VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- One solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months⁵⁸
- Four LIPs hired within 18 months before the site visit
- Eleven LIPs re-privileged within 12 months before the visit
- No providers who underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
 - Privileges requested by the provider
 - Facility-specific
 - Service-specific
 - Provider-specific⁵⁹
 - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
 - Criteria defined in advance
 - Use of required criteria in FPPEs for selected specialty LIPs
 - Results and time frames clearly documented
 - Evaluation by another provider with similar training and privileges
 - Executive Committee of the Medical staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
 - Criteria specific to the service or section
 - Use of required criteria in OPPEs for selected specialty LIPs

⁵⁸ The 18-month review period was from November 6, 2018, through May 6, 2019. The 12-month review period covered May 6, 2018, through May 6, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

⁵⁹ According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

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

Medical Staff Privileging Conclusion

Generally, the facility generally met requirements with the above performance indicators. The OIG made no recommendations.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.⁶⁰

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.⁶¹

VHA requires its facilities to have the “capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;” however, for facilities that do not have inpatient mental health services, that “capacity” could mean facilitating care at a nearby VA or non-VA facility.⁶²

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities’ efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.⁶³ Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,⁶⁴

⁶⁰ VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

⁶¹ Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

⁶² VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

⁶³ VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

⁶⁴ VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,⁶⁵ and National Fire Protection Association standards.⁶⁶ The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.⁶⁷

In all, the OIG team inspected eight areas at the facility—the community living center; day procedure unit; urgent care center; the primary care, ophthalmology, dental, physical therapy, and audiology clinics. The team also inspected the Abilene VA Clinic. The team also reviewed the emergency management program. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Community based outpatient clinic
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Locked inpatient mental health unit⁶⁸
 - Mental health environment of care rounds
 - Nursing station security

⁶⁵ The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA’s mission is to assure safe and healthy working conditions “by setting and enforcing standards and by providing training, outreach, education, and assistance.” <https://www.osha.gov/about.html>. (This website was accessed on June 28, 2018.)

⁶⁶ The National Fire Protection Association (NFPA) is a global nonprofit organization “devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards.” <https://www.nfpa.org/About-NFPA>. (This website was accessed on June 28, 2018.)

⁶⁷ TJC. Environment of Care standard EC.02.05.07.

⁶⁸ The facility did not have an inpatient mental health unit.

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

Environment of Care Conclusion

Generally, the facility met cleanliness and safety requirements associated with the above performance indicators. The OIG did not note any issues with the availability of medical equipment and supplies. The OIG made no recommendations.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.⁶⁹ Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.⁷⁰

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.⁷¹

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;⁷² and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
 - Monthly summary of findings to the director
 - Quarterly trend reports to the director
 - Quality Management Committee’s review of monthly and quarterly trend reports
 - Actions taken to resolve identified problems
- Pharmacy operations
 - Staff restrictions for monthly review of balance adjustments⁷³
- Requirements for controlled substances inspectors

⁶⁹ Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (The website was accessed on March 7, 2019.)

⁷⁰ American Society of Health-System Pharmacists, “ASHP Guidelines on Preventing Diversion of Controlled Substances,” *American Journal of Health-System Pharmacists*, 74, no. 5 (March 1, 2017): 325-348.

⁷¹ VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

⁷² The two quarters were from October 1, 2018, through March 31, 2019.

⁷³ Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- No conflicts of interest
- Appointed in writing by the director for a term not to exceed three years
- Hiatus of one year between any reappointment
- Completion of required annual competency assessment
- Controlled substances area inspections
 - Completion of monthly inspections
 - Rotations of controlled substances inspectors
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of controlled substances orders
 - Performance of routine controlled substances inspections
- Pharmacy inspections
 - Monthly physical counts of the controlled substances in the pharmacy
 - Completion of inspections on day initiated
 - Security and verification of drugs held for destruction⁷⁴
 - Accountability for all prescription pads in pharmacy
 - Verification of hard copy controlled substances prescriptions
 - Verification of twice a week (three days apart) inventories of the main vault⁷⁵
 - Quarterly inspections of emergency drugs
 - Monthly checks of locks and verification of lock numbers
- Facility review of override reports⁷⁶

⁷⁴ According to VHA Directive 1108.02(1), the Destructions File Holding Report “lists all drugs awaiting local destruction or turn-over to a reverse distributor.” Controlled substances inspectors “must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.”

⁷⁵ VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

⁷⁶ When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists’ review of medications ordered by the providers.

Medication Management Conclusion

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the pharmacy operations, pharmacy inspections, and facility review of override reports. The OIG identified noncompliance with monthly summaries of findings and quarterly trend reports to the director, Quality Executive Board reviews of the program reports, completion of required annual competencies, and verification of controlled substance orders that warranted recommendations for improvement.

Specifically, VHA requires that the controlled substances coordinator provide the director with a monthly summary of findings and a quarterly trends report that includes discrepancies and vulnerabilities identified during monthly controlled substances inspections.⁷⁷ Of the six monthly reports reviewed, the OIG found that two monthly reports from January 2019 and February 2019 were not provided to the director. Also, the OIG found that quarterly trends reports from October 2018 to March 2019 were also not provided to the director. This oversight left the facility vulnerable to unauthorized access, diversion, and loss. The acting controlled substances coordinator could not locate the two monthly summary reports and cited a lack of oversight. Additionally, the acting controlled substance coordinator was unaware of the requirement to complete quarterly trend reports.

Recommendation 4

4. The facility director ensures that the controlled substance coordinator provides the monthly summary of findings and quarterly trends report to the director and monitors the controlled substance coordinator's compliance.

Facility concurred.

Target date for completion: December 27, 2019

Facility response: The facility director will ensure that the controlled substance coordinator provides monthly summaries of findings and quarterly trends to the director. The facility director will monitor the controlled substance coordinator's compliance to submit monthly/quarterly reports to the Quality Executive Board until a 90% compliance is sustained for a period of 6 months.

⁷⁷ VHA Directive 1108.02(1).

VHA also requires the Quality Management Committee (referred to as the Quality Executive Board at this facility) to review controlled substance inspection program reports at least quarterly for adherence with controlled substance inspection program requirements.⁷⁸ The OIG did not find documentation that controlled substances program reports were reviewed by the Quality Executive Board. Failure to review quarterly reports can result in missed opportunities to identify areas for improvement and implement corrective actions. The acting controlled substances coordinator was assigned this role in December 2018 and was not aware of the requirement.

Recommendation 5

5. The facility director makes certain that the Quality Executive Board reviews the controlled substance inspection program reports at least quarterly and monitors the quality manager's compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The facility director will ensure that the Quality Executive Board (QEB) reviews the controlled substance inspection program reports at least quarterly. The facility director will monitor that quarterly reviews are included in QEB meeting minutes until 90% compliance is sustained for a period of 6 months.

VHA requires competency assessments of the controlled substances inspectors are performed and documented annually.⁷⁹ The OIG did not find documentation that required annual competency assessments were completed for 6 of 10 controlled substances inspectors. This resulted in controlled substances inspectors performing inspections without a formal evaluation of their knowledge, skills, and abilities. The acting controlled substance coordinator cited staffing issues affecting compliance with requirements.

Recommendation 6

6. The facility director makes certain that the controlled substances coordinator performs and documents competency assessments of the controlled substance inspectors annually and monitors controlled substances coordinator's compliance.

⁷⁸ VHA Directive 1108.02(1).

⁷⁹ VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: November 27, 2019

Facility response: The Facility Director will ensure the controlled substances coordinator performs and documents competency assessments of the controlled substance inspectors annually at a minimum. The facility director monitors the currency of competency assessments through quarterly reviews of QEB meeting minutes until 90% compliance is sustained for a period of 6 months.

In addition, VHA requires that during controlled substances area inspections, inspectors verify there is evidence of a written or electronic controlled substances order for five random dispensing activities.⁸⁰ The OIG found that controlled substances inspectors did not verify controlled substances orders for five randomly selected dispensing activities in all four areas reviewed for October 1, 2018, through March 31, 2019. Failure to verify electronic or written orders may result in missed opportunities to identify potential drug diversion activities and any discrepancies related to controlled substances. The acting controlled substance coordinator acknowledged that a lack of staff impacted the ability to meet requirements.

Recommendation 7

7. The facility director makes certain the controlled substances inspectors verify controlled substances orders for five random dispensing activities during monthly inspections and monitors the inspectors' compliance.

Facility concurred.

Target date for completion: December 27, 2019

Facility response: The facility director will ensure the controlled substance program coordinator verifies that controlled substance orders for five random dispensing activities during monthly inspections. The facility director monitors compliance through quarterly reviews of QEB meeting minutes until 90% compliance is sustained for a period of 6 months.

⁸⁰ VHA Directive 1108.02(1).

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

The Department of Veterans Affairs uses the term “military sexual trauma” (MST) to refer to a “psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.”⁸¹ MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.⁸²

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.⁸³ Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.⁸⁴

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.⁸⁵ Those who screen positive must have access to appropriate MST-related care.⁸⁶ VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.⁸⁷

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.⁸⁸ All mental health and primary care providers must complete MST mandatory

⁸¹ VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

⁸² Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

⁸³ VHA Directive 1115.

⁸⁴ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, (amended November 16, 2015). (This VHA handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

⁸⁵ VHA Directive 1115 states that “MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities.”

⁸⁶ VHA Directive 1115.

⁸⁷ VHA Handbook 1160.01.

⁸⁸ VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.⁸⁹

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 22 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

Mental Health Conclusion

Generally, the OIG found compliance with requirements for the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. However, the team noted a concern with mental health and primary care providers completing MST mandatory training that warranted a recommendation for improvement.

Specifically, VHA requires that all mental health and primary care providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after entering their position.⁹⁰ The OIG found that for the 20 providers selected for review, 9 of 12 employees hired after July 1, 2012, did not complete training within 90 days, and

⁸⁹ VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

⁹⁰ VHA Directive 1115.01.

4 of 20 providers did not complete the training at all. This could potentially prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST. The MST coordinator and chief of social work reported a lack of communication among facility Talent Management System coordinators, nonsupervisory program staff, and supervisors of clinical services as the reason for noncompliance.

Recommendation 8

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

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The facility director will confirm that mental health and primary care providers will complete military sexual trauma mandatory training within 90 days after entering their position. The chief of staff will ensure providers complete training as mandated through monthly audits reported to Medical Executive Board until 90% compliance gained and sustained for 6 consecutive months.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."⁹¹ The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.⁹²

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepressant drugs, psychotherapy, or a combination of both."⁹³

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.⁹⁴ The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."⁹⁵ In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.⁹⁶ Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.⁹⁷ The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

⁹¹ Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs, Mental Health Featured Article*, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

⁹² *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. <https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf>. (The website was accessed November 20, 2018.)

⁹³ Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. <https://www.cdc.gov/aging/mentalhealth/depression.htm>. (The website was accessed on March 8, 2019.)

⁹⁴ American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

⁹⁵ TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

⁹⁶ VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

⁹⁷ TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.⁹⁸

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 44 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.⁹⁹ The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

The OIG found compliance with providers documenting justification for medication initiation, validating patient and/or caregiver understanding when education was provided, and reconciling the patients' medications relevant to the episode of care. However, the OIG identified inadequate patient and/or caregiver education specific to newly prescribed medications that warranted a recommendation for improvement.

Specifically, TJC requires that clinicians educate patients and families about safe and effective use of medications.¹⁰⁰ The OIG estimated that clinicians provided this education to 64 percent of the patients at the facility, based on electronic health records reviewed.¹⁰¹ Providing medication education is important for patients to be able to manage their health at home. The chief of pharmacy, mental health pharmacist, and ADPCS reported that patient education and documentation templates for walk-in patients differed from templates used for patients with appointments and verbalized an urgency to standardize templates for all patients.

⁹⁸ VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

⁹⁹ The seven selected antidepressant medications are amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, and paroxetine.

¹⁰⁰ TJC, Provision of Care standard PC.02.03.01 and Record of Care, Treatment, and Services standard RC.02.01.01.

¹⁰¹ The OIG is 95 percent confident that the true compliance rate is somewhere between 48.8 and 77.7 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 9

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

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The chief of staff will make certain clinicians provide and document patient/caregiver education about the safe and effective use of newly prescribed medication(s). The chief of staff will monitor for compliance of documentation in a minimum of 50 records per month until 90% compliance is sustained and maintained for 6 months.

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

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.¹⁰² Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.¹⁰³ In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.¹⁰⁴ Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.¹⁰⁵

VA is authorized to provide “gender-specific services, such as Papanicolaou tests (Pap smears),” to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.^{Footnote 106}

VHA requires that each facility have a “full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women’s health care.” VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women’s health program. Each facility must also have a “Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women’s Health Program strategic plan.” The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.¹⁰⁶

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.¹⁰⁷

¹⁰² Centers for Disease Control and Prevention. “Cervical Cancer” *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

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

¹⁰⁴ Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

¹⁰⁵ Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

¹⁰⁶ VHA Directive 1330.01(2).

¹⁰⁷ VHA Directive 1330.01(2).

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 16 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

Women’s Health Conclusion

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

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women’s health medical director; “representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a

member from executive leadership.”¹⁰⁸ The November 2018 and February 2019 Women Veterans Health Committee (referred to as the Women Veterans’ Advisory Committee at this facility) lacked representation from primary care, medical and/or surgical subspecialties, radiology, laboratory, and executive leadership. This resulted in a lack of expertise in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. The women veterans program manager acknowledged the requirements for representation and stated the lack of representation was due to misinterpretation of the directive.

Recommendation 10

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

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The facility director confirmed that the core membership of the Women Veterans Advisory Committee was reflected in the updated charter. The facility director ensured the Women Veterans Advisory Committee Charter reflected inclusion of “representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership.” as required by VHA Directive 1330.01(2). The chief of staff will monitor Women Veterans Advisory Committee attendance until 90% of core members/designee achieve 90% compliance for two quarters as reported to the facility director in Leadership Council.

¹⁰⁸ VHA Directive 1330.01(2).

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a “unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations.” An urgent care center (UCC) “provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries.”¹⁰⁹ A variety of emergency services may exist, dependent on “capability, capacity, and function of the local VA medical facility;” however, emergency care must be uniformly available in all VHA emergency departments and UCCs.¹¹⁰

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide “unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week.” VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that “evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care.”¹¹¹

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can “undermine the timeliness of care and, ultimately, patient safety.” Effective management processes that “support patient flow [in the emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care.”¹¹²

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.¹¹³

¹⁰⁹ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

¹¹⁰ VHA Directive 1101.05(2).

¹¹¹ VHA Directive 1101.05(2).

¹¹² TJC. Leadership standard LD.04.03.11.

¹¹³ VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing Emergency Medicine Improvement initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.¹¹⁴ Managers must ensure medications are securely stored,¹¹⁵ a psychiatric intervention room is available,¹¹⁶ and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.¹¹⁷

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, the OIG team reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
 - Presence of an emergency department or UCC
 - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
 - Emergency department/UCC operating hours
 - Workload capture process
- Staffing for emergency department/UCC
 - Dedicated medical director
 - At least one licensed physician privileged to staff the department at all times
 - Minimum of two registered nurses on duty during all hours of operation
 - Backup call schedules for providers
- Support services for emergency department/UCC
 - Access during regular hours, off hours, weekends, and holidays
 - On-call list for staff required to respond
 - Licensed independent mental health provider available as required for the facility's complexity level

¹¹⁴ VHA Directive 1101.05(2).

¹¹⁵ TJC. Medication Management standard MM.03.01.01.

¹¹⁶ A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

¹¹⁷ VHA Directive 1101.05(2).

- Telephone message system during non-operational hours
- Inpatient provider available for patients requiring admission
- Patient flow
 - EDIS tracking program
 - Emergency department patient flow evaluation
 - Diversion policy
 - Designated bed flow coordinator
- General safety
 - Directional signage to after-hours emergency care
 - Fast tracks¹¹⁸
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
 - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

The facility generally complied with many of the performance indicators used to assess the high-risk process of the operations and management of the UCC. However, the OIG identified noncompliance with the workload capture process, the lack of a backup call schedule for UCC providers, and failure to report patient data to the VHA Emergency Medicine National Program Office.

VHA uses stop codes to capture patient workload and comparative productivity data as well as to identify the level of clinical service provided.¹¹⁹ Facilities are required to use a stop code that

¹¹⁸ The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

¹¹⁹ A stop code is a nomenclature that identifies each type of patient encounter in a facility clinical workload. VHA collects clinical workload data that supports the provision of patient care, resource allocation, performance measurement, quality management, and third-party collections. Department of Veterans Affairs Financial Policy, *Cost Accounting, Appendix A - VHA Standardization of Stop Codes*, vol. XIII, February 2019.

identifies patients receiving UCC services.¹²⁰ The OIG found that the facility used the general internal medicine services stop code for the identification of UCC patients.¹²¹ As a result, the national program office was unaware that a UCC was operational at the facility. The chief of staff's administrative officer explained the appropriate UCC stop code was used initially when the facility closed inpatient medical surgical beds and converted the emergency department to a UCC. The facility was subsequently advised by the VHA Office of Finance to use the general internal medicine stop code.¹²²

Recommendation 11

11. The facility director ensures that urgent care center patients are assigned the appropriate stop codes to capture correct patient workload, productivity, and level of service and monitors compliance.¹²³

Facility concurred.

Target date for completion: October 1, 2019

Facility response: WTVAHCS no longer offers Urgent Care Clinic Services as of October 1, 2019 and maintains use of the general internal medicine services stop code for identification of encounters completed within the newly formed General Medicine Clinic. WTVAHCS directs Veterans in need of Urgent Care Services to the retail network Urgent Care Centers within the community of the main facility and CBOC communities. Information regarding this transition was shared with organizational stakeholders, staff and Veterans indicating the site now operates as a General Medicine Clinic.

Additionally, VHA requires that a UCC has appropriately educated and qualified emergency care professionals physically present in the UCC during all hours of operation. To ensure adequate staffing, VHA also requires a "written provider staffing contingency plan that includes a back-up call schedule to address situations where expedient mobilization of provider resources are needed."¹²⁴ The OIG found that the UCC lacked a written contingency plan and backup call schedule, which could impact the facility's ability to provide uninterrupted and timely patient care. The chief of staff and UCC medical director stated the facility has an informal contingency plan that diverts providers, who are performing other duties within the facility, to the UCC.

¹²⁰ VHA Directive 1101.05(2) requires the use of stop code 131 to identify UCC patients; the facility was using general internal medicine stop code 301.

¹²¹ VSSC (VHA Support Service Center) Clinical Inventory Facility Profile Report.

¹²² This was confirmed by copies of email communications, provided to the OIG, which dated back to October 2014.

¹²³ The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

¹²⁴ VHA Directive 1101.05(2).

Recommendation 12

12. The chief of staff ensures that a written provider staffing contingency plan and backup call schedule are maintained for urgent care center providers and monitors compliance.¹²⁵

Facility concurred.

Target date for completion: October 1, 2019

Facility response: WTVAHCS no longer offers Urgent Care Clinic Services as of October 1, 2019. The site does not have the necessity to maintain a provider staffing contingency plan and backup call scheduled as there are no urgent care or after-hours services provided. WTVAHCS directs Veterans in need of Urgent Care Services to the retail network Urgent Care Centers within the community of the main facility and CBOC communities. Information regarding this transition was shared with organizational stakeholders, staff and Veterans indicating the site now operates as a General Medicine Clinic.

VHA requires that VA emergency departments and UCCs fully implement the Emergency Department Integration Software (EDIS) tracking program to manage patient flow and utilize the data to improve the quality of emergent and urgent care. The Emergency Medicine Management Tool (EMMT), which is populated by the EDIS program, is used to communicate patient data to the VHA Emergency Medicine National Program Office.¹²⁶ The OIG did not find EDIS data uploaded to the Emergency Medicine Management Tool.¹²⁷ The acting nurse manager reported that UCC staff recorded data using an EDIS template form obtained from the VA intranet. However, the information on this form was not uploaded to the EMMT. As a result, UCC operations at the facility could not be tracked and monitored by the VHA Emergency Medicine National Program Office, and as a result, VHA headquarters was not aware that a UCC existed at the facility. This also made it difficult for the facility to compare productivity data in the EMMT database to improve patient flow and quality of care. UCC staff were unaware that data entered into this version of the software tracking program were not transmitted to the national program office.

¹²⁵ The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

¹²⁶ Emergency Department Integration Software (EDIS) is a web-based program that extends the Computerized Patient Record System to track and manage the flow of patient care in emergency department and UCC settings, and VHA Directive 1101.05(2).

¹²⁷ According to VHA Handbook 1101.05(2), the EMMT is a national database that uses data collected from utilization of the EDIS tracking software program to generate daily patient flow and productivity metrics for each emergency department and UCC.

Recommendation 13

13. The facility director confirms that the urgent care center implements the Emergency Department Integration Software tracking program and transmits data to the Emergency Medicine Management Tool and monitors compliance.¹²⁸

Facility concurred.

Target date for completion: October 1, 2019

Facility response: WTVAHCS no longer offers Urgent Care Clinic Services as of October 1, 2019. There is no patient data to report to EDIS as the site no longer meets the reporting criteria for this software. WTVAHCS directs Veterans in need of Urgent Care Services to the retail network Urgent Care Centers within the community of the main facility and CBOC communities. Information regarding this transition was shared with organizational stakeholders, staff and Veterans indicating the site now operates as a General Medicine Clinic. This recommendation is no longer applicable to WTVAHCS.

¹²⁸ The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer reviews • Patient safety • Resuscitation episode review 	<ul style="list-style-type: none"> • The Code Blue/Rapid Response Team Committee reviews each resuscitative episode under the facility's responsibility. 	<ul style="list-style-type: none"> • The patient safety manager completes a minimum of eight required root cause analyses each fiscal year. • The facility leaders review a Patient Safety Annual Report at the end of the fiscal year.
Medical Staff Privileging	<ul style="list-style-type: none"> • Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	<ul style="list-style-type: none"> • Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The controlled substance coordinator provides the monthly summary of findings and quarterly trends report to the director. • The Quality Executive Board reviews the controlled substance inspection program reports at least quarterly. • The controlled substances coordinator performs and documents competency assessments of the controlled substance inspectors annually. • Controlled substances inspectors verify CS orders for five randomly selected dispensing activities during monthly inspections.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	<ul style="list-style-type: none"> • Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Mental health and primary care providers complete military sexual trauma mandatory training within the required time frame.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Geriatric Care: Antidepressant Use among the Elderly	<ul style="list-style-type: none"> • Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation 	<ul style="list-style-type: none"> • Clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications. 	<ul style="list-style-type: none"> • None
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	<ul style="list-style-type: none"> • Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Women Veterans Advisory Committee is comprised of the required core members.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<p>High-Risk Processes: Operations and Management of Emergency Departments and UCCs</p>	<ul style="list-style-type: none"> • General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Appropriate stop codes are utilized to capture UCC patient workload, productivity, and identification of level of service. • A written provider staffing contingency plan and backup call schedule are maintained for UCC providers. • The UCC implements the EDIS tracking program and transmit data to the EMMT.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated¹²⁹ facility reporting to VISN 17.¹³⁰

**Table B.1. Facility Profile for West Texas VA Health Care System (519)
(October 1, 2015, through September 30, 2018)**

Profile Element	Facility Data FY 2016 ¹³¹	Facility Data FY 2017 ¹³²	Facility Data FY 2018 ¹³³
Total medical care budget in dollars	\$129,171,180	\$126,773,005	\$144,662,022
Number of:			
• Unique patients	18,360	17,883	18,295
• Outpatient visits	177,178	169,640	171,238
• Unique employees ¹³⁴	438	428	432
Type and number of operating beds:			
• Community living center	40	40	40
• Domiciliary	40	40	40
Average daily census:			
• Community living center	24	29	29
• Domiciliary	29	34	33

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

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

¹²⁹ Associated with a medical residency program.

¹³⁰ The VHA medical centers are classified according to a facility complexity model; a designation of “3” indicates a facility with “low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs.”

¹³¹ October 1, 2015, through September 30, 2016.

¹³² October 1, 2016, through September 30, 2017.

¹³³ October 1, 2017, through September 30, 2018.

¹³⁴ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles¹³⁵

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

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)¹³⁶

Location	Station No.	Primary Care Workload/Encounters	Mental Health Workload/Encounters	Specialty Care Services ¹³⁷ Provided	Diagnostic Services ¹³⁸ Provided	Ancillary Services ¹³⁹ Provided
Odessa, TX	519GA	9,975	3,944	Poly-trauma Eye	n/a	Nutrition Pharmacy Weight management
Hobbs, NM	519GB	1,714	831	Poly-trauma	n/a	Pharmacy Nutrition
Fort Stockton, TX	519GD	525	34	n/a	n/a	n/a

¹³⁵ Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

¹³⁶ The definition of an “encounter” can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a “professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.”

¹³⁷ Specialty care services refer to non-primary care and non-mental health services provided by a physician.

¹³⁸ Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

¹³⁹ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

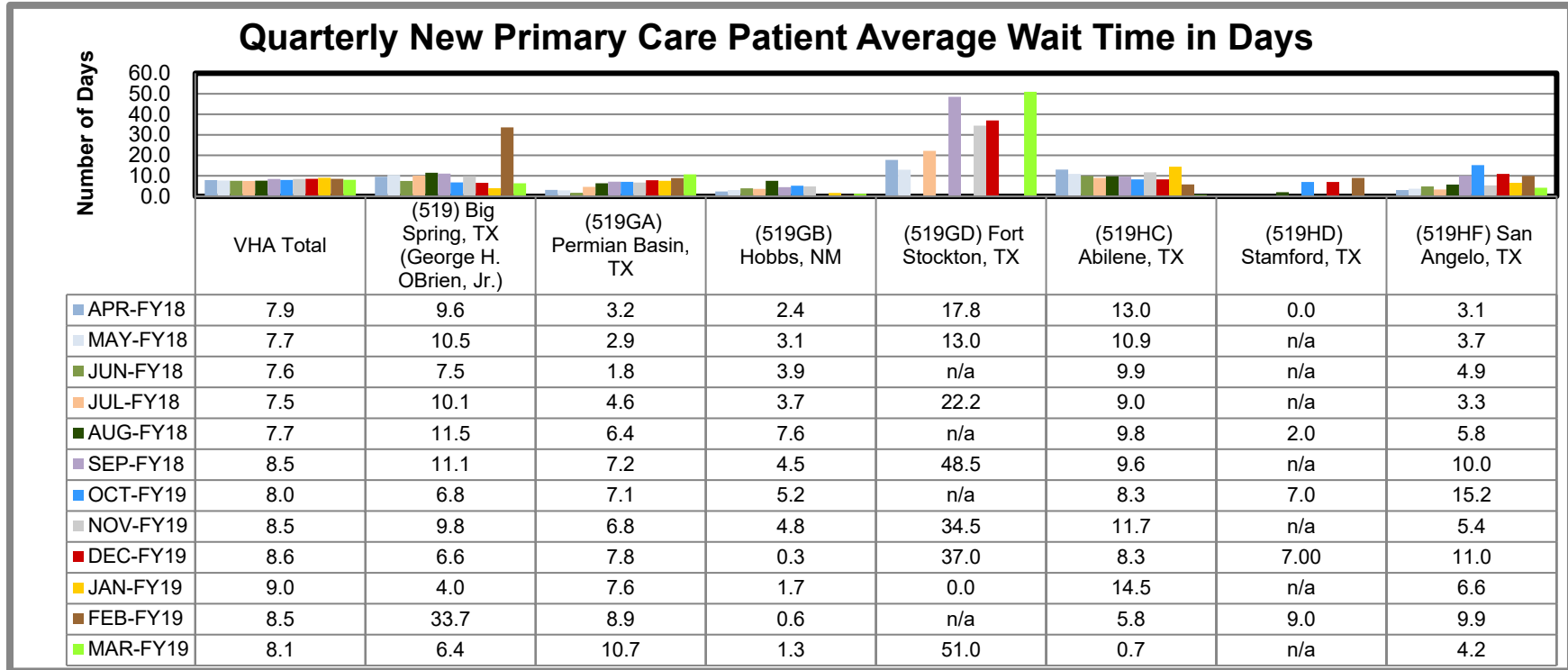
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹³⁷ Provided	Diagnostic Services ¹³⁸ Provided	Ancillary Services ¹³⁹ Provided
Abilene, TX	519HC	9,985	4,948	Dermatology Poly-trauma Eye	n/a	Nutrition Pharmacy Weight management
Stamford, TX	519HD	243	n/a	n/a	n/a	n/a
San Angelo, TX	519HF	8,935	3,646	Dermatology Poly-trauma	n/a	Nutrition Pharmacy

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics¹⁴⁰

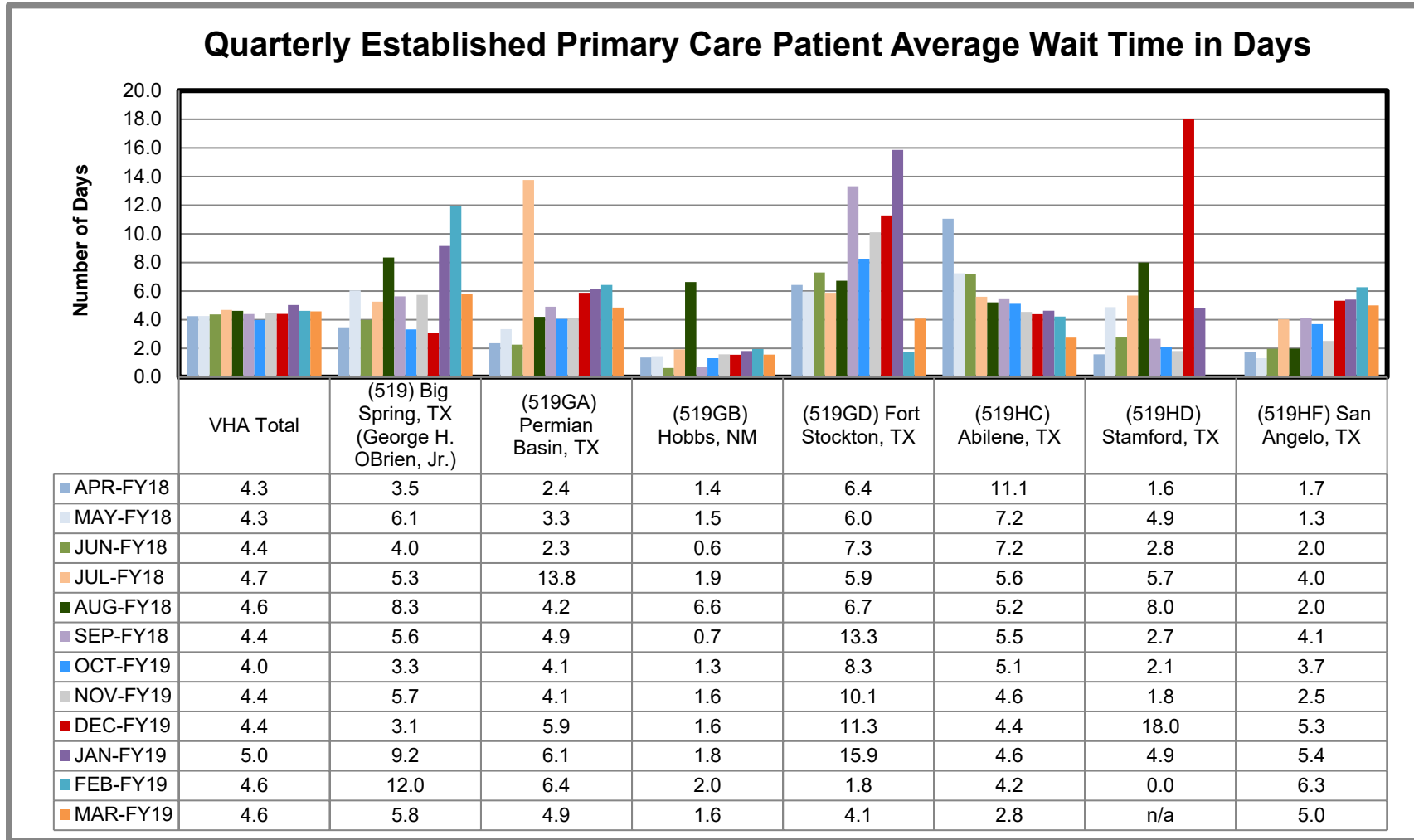


Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the facility's explanation for the increased wait times for the Fort Stockton, TX (519GD) CBOC.

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

¹⁴⁰ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.



Source: VHA Support Service Center

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

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

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹⁴¹

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

¹⁴¹ VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

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

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

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

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions¹⁴²

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

¹⁴² *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on September 3, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 9, 2019

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Comprehensive Healthcare Inspection of the West Texas VA Health Care System, Big Spring, TX

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

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

Thank you for the opportunity to review and respond to the OIG Comprehensive Healthcare Inspection Report (CHIP) provided for West Texas VA Health Care System in Big Spring, Texas.

I have reviewed and concur with the findings, recommendations and action plans submitted in the report.

(Original signed by:)

Jeff Milligan

Network Director, VA Heart of Texas Health Care Network

VISN 17

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

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 9, 2019

From: Interim Director, West Texas VA Health Care System (519/00)

Subj: Comprehensive Healthcare Inspection of the West Texas VA Health Care System, Big Spring, TX

To: Director, VA Heart of Texas Health Care Network (10N17)

Thank you for the opportunity to review the OIG Comprehensive Healthcare Inspection Report (CHIP) provided for West Texas VA Health Care System in Big Spring, Texas.

I appreciate the professionalism and feedback provided to our staff during the onsite CHIP review conducted May 6-9, 2019.

I have reviewed and concur with the findings, recommendations and action plans submitted as part of this report.

(Original signed by:)

Jason Cave

Interim Director

West Texas VA Health Care System

Big Spring, Texas

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

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