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

**Office of Healthcare Inspections**

**Report No. 16-00118-321**

# Combined Assessment Program Review of the Amarillo VA Health Care System Amarillo, Texas

**June 14, 2016**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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# Glossary

| | |
|---|---|
| AD | advance directive |
| CAP | Combined Assessment Program |
| CSP | compounded sterile product |
| CT | computed tomography |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Amarillo VA Health Care System |
| FY | fiscal year |
| MH | mental health |
| NA | not applicable |
| NM | not met |
| OIG | Office of Inspector General |
| OR | operating room |
| QSV | quality, safety, and value |
| VHA | Veterans Health Administration |

# Table of Contents

# Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of March 21, 2016.

**Review Results:** The review covered seven activities. We made no recommendations in the following two activities:

- Computed Tomography Radiation Monitoring
- Advance Directives

The facility's reported accomplishment was improvement in opioid safety through an informed consent process.

**Recommendations:** We made recommendations in the following five activities:

*Quality, Safety, and Value:* Set triggers for when a Focused Professional Practice Evaluation for cause is indicated. Consistently implement individual improvement actions recommended by the Peer Review Committee. Ensure Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.

*Environment of Care:* Ensure designated employees follow facility policy for identification of individuals entering the facility after normal business hours. Properly secure medical waste/biohazard containers.

*Medication Management:* Perform and consistently document monthly cleaning of walls and light fixtures in all compounding areas.

*Coordination of Care:* Ensure sending nurses document transfer assessments.

*Suicide Prevention Program:* Ensure new clinical employees complete suicide risk management training within the required timeframe. Include in Suicide Prevention Safety Plans the contact numbers of family or friends for support and an assessment of available lethal means and how to keep the environment safe. Review patients' high-risk flags at least every 90 days.

## Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–30, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

# Objectives and Scope

## Objectives

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

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

## Scope

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

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

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program

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

The review covered facility operations for FY 2015 and FY 2016 through March 24, 2016, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status

on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas,* Report No. 13-02313-310, September 13, 2013).

During this review, we presented crime awareness briefings for 142 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

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

# Reported Accomplishment

## Opioid Safety Through an Informed Consent Process

In October 2014, VHA Support Service Center data showed that facility providers had obtained opioid informed consent from and provided education to only 11 of 1,698 patients (0.6 percent). In an attempt to meet the VHA benchmark of 100 percent, the facility developed group education sessions focusing on opioid safety. These sessions allowed a provider to present the education required to obtain opioid consent to multiple patients at one time to increase education and patient compliance. At the start-up of these sessions in April 2015, the VHA Support Service Center report showed 532 of 1,698 patients (31 percent) had signed opioid consent forms and received education. The feedback provided by patients who attended these sessions indicated high satisfaction with attendance and receptiveness to the teaching method. As of June 2015, the facility showed a significant gain of 1,627 of 2,065 patients (79 percent) had signed opioid consent forms and received education.

# Results and Recommendations

## QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director.<br>• The committee routinely reviewed aggregated data. | | |
| X | Credentialing and privileging processes met selected requirements:<br>• Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data.<br>• Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws.<br>• The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.<br>• The facility followed its policy when employees' licenses expired. | • The facility had not set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. | **1.** We recommended that the facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| X | Protected peer reviews met selected requirements:<br>• Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation.<br>• When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions. | • In three cases, there was no evidence that clinical managers implemented individual improvement actions recommended by the Peer Review Committee. | **2.** We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance. |
| X | Utilization management met selected requirements:<br>• The facility completed at least 75 percent of all required inpatient reviews.<br>• Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database.<br>• The facility had designated an interdisciplinary group to review utilization management data. | • For 16 of the 229 cases (7 percent) referred to Physician Utilization Management Advisors October 1–December 31, 2015, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database. | **3.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance. |
| | Patient safety met selected requirements:<br>• The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database.<br>• The facility completed the required minimum of eight root cause analyses.<br>• The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident.<br>• At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness. | | |
| | Overall, senior managers actively participated in QSV activities. | | |
| | The facility met any additional elements required by VHA or local policy. | | |

## EOC

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

We inspected the medical/surgical and intensive care inpatient units, the community living center, the Emergency Department, the OR, and the dental and women's clinics. Additionally, we reviewed relevant documents and 25 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed for General EOC | Findings | Recommendations |
|---|---|---|---|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics. | | |
| | The facility conducted an infection prevention risk assessment. | | |
| | Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data. | | |
| | The facility had established a process for cleaning equipment between patients. | | |
| | The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques. | | |
| X | The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements. | Facility policy for identification of individuals entering the facility reviewed:<br>• Employees did not maintain a log of individuals entering the facility after normal business hours. | **4.** We recommended that designated employees follow the facility policy for identification of individuals entering the facility after normal business hours and that facility managers monitor compliance. |

| NM | Areas Reviewed for General EOC (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility met fire safety requirements. | | |
| | The facility met environmental safety requirements. | | |
| X | The facility met infection prevention requirements. | • In two of five patient care areas, medical waste/biohazard containers were not properly secured. | **5.** We recommended that facility managers ensure medical waste/biohazard containers are properly secured and monitor compliance. |
| | The facility met medication safety and security requirements. | | |
| | The facility met privacy requirements. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | **Areas Reviewed for Dental Clinic** | | |
| | Dental clinic employees completed bloodborne pathogens training within the past 12 months. | | |
| | Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets. | | |
| NA | Designated dental clinic employees received laser safety training in accordance with local policy. | | |
| | The facility tested dental water lines in accordance with local policy. | | |
| X | The facility met environmental safety and infection prevention requirements in the dental clinic. | • In the dental clinic, medical waste/biohazard containers were not properly secured. | See recommendation 5. |
| NA | The facility met laser safety requirements in the dental clinic. | | |

| NM | Areas Reviewed for Dental Clinic (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | **Areas Reviewed for the OR** | | |
| | The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen. | | |
| | The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination. | | |
| | OR housekeepers received training on OR cleaning/disinfection in accordance with local policy. | | |
| | The facility monitored OR temperature, humidity, and positive pressure. | | |
| | The facility met fire safety requirements in the OR. | | |
| | The facility met environmental safety requirements in the OR. | | |
| | The facility met infection prevention requirements in the OR. | | |
| | The facility met medication safety and security requirements in the OR. | | |
| | The facility met laser safety requirements in the OR. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |

## Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy technicians. Additionally, we inspected three areas where sterile products are compounded. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had a policy on preparation of CSPs that included required components:<br>• Pharmacist CSP preparation or supervision of preparation except in urgent situations<br>• Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator<br>• Environmental quality and control of ante and buffer areas<br>• Hood certification initially and every 6 months thereafter<br>• Cleaning procedures for all surfaces in the ante and buffer areas | | |
| | The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| NA | If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility:<br>• Food and Drug Administration registration<br>• Current Drug Enforcement Agency registration if compounding controlled substances | | |
| | The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility. | | |
| | All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures. | | |
| | The facility had a process to track and report CSP medication errors, including near misses. | | |
| | The facility met design and environmental safety controls in compounding areas. | | |
| NA | The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products. | | |
| | The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas. | | |
| | Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure. | | |
| | An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing. | | |
| X | The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies. | • There was inconsistent documentation of monthly cleaning of walls and light fixtures in the compounding areas as required by local standard operating procedures. | **6.** We recommended that facility managers ensure employees perform and consistently document monthly cleaning of walls and light fixtures in all compounding areas and monitor compliance. |
| | During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months. | | |
| | Prepared CSPs had labels with required information prior to delivery to the patient care areas:<br>• Patient identifier<br>• Date prepared<br>• Admixture components<br>• Preparer and checker identifiers<br>• Beyond use date | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |

## Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had a policy that addressed patient discharge and scheduling discharges early in the day. | | |
| | The facility had a policy that addressed temporary bed locations, and it included:<br>• Priority placement for inpatient beds given to patients in temporary bed locations<br>• Upholding the standard of care while patients are in temporary bed locations<br>• Medication administration<br>• Meal provision | | |
| | The Facility Director had appointed a Bed Flow Coordinator with a clinical background. | | |
| | Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission.<br>• When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | • When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented. | | |
| | Nurses completed admission assessments within 1 day of the patient's admission. | | |
| | When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer.<br>• When resident physicians wrote the transfer notes, attending physicians documented adequate supervision.<br>• Receiving physicians documented transfers. | | |
| X | When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes. | • For 3 of the 17 applicable EHRs, sending nurses did not document transfer assessments. | **7.** We recommended that sending nurses document transfer assessments and that facility managers monitor compliance. |
| | Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels.<br>• When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision.<br>• When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for five CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program. | | |
| | The facility had a CT/imaging/radiation safety policy or procedure that included:<br>• A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance<br>• CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer<br>• A process for managing/reviewing CT protocols and procedures to follow when revising protocols<br>• Radiologist review of appropriateness of CT orders and specification of protocol prior to scans | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months. | | |
| | A medical physicist tested a sample of CT protocols at least annually. | | |
| | A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service. | | |
| NA | If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information. | | |
| | CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification. | | |
| | There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring. | | |
| | If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had an AD policy that addressed:<br>• AD notification, screening, and discussions<br>• Proper use of AD note titles | | |
| | Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening. | | |
| | When patients provided copies of their current ADs, employees had scanned them into the EHR.<br>• Employees correctly posted patients' AD status. | | |
| | Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs.<br>• When inpatients requested a discussion, employees documented the discussion and used the required AD note titles. | | |
| | The facility met any additional elements required by VHA or local policy. | | |

## Suicide Prevention Program

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period October 1, 2014–September 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

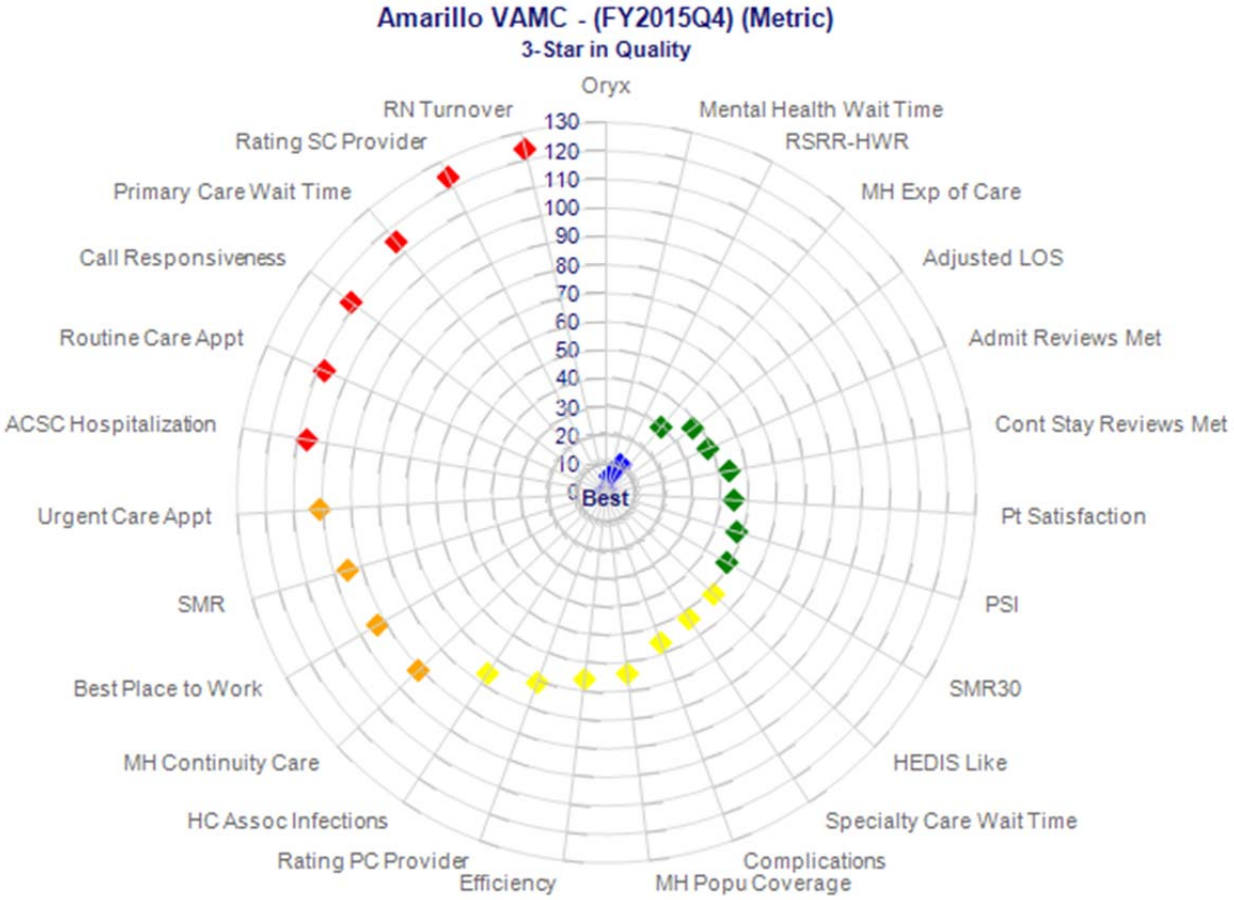
| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had a full-time Suicide Prevention Coordinator. | | |
| | The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide. | | |
| | The facility had a process to follow up on high-risk patients who missed MH appointments. | | |
| X | The facility provided training within required timeframes:<br>• Suicide prevention training to new employees<br>• Suicide risk management training to new clinical employees | • Three of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired. | **8.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance. |
| | The facility provided at least five suicide prevention outreach activities to community organizations each month. | | |
| | The facility completed required reports and reviews regarding patients who attempted or completed suicide. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Clinicians assessed patients for suicide risk at the time of admission. | | |
| | Clinicians appropriately placed Patient Record Flags:<br>• High-risk patients received Patient Record Flags.<br>• Moderate- and low-risk patients did not receive Patient Record Flags. | | |
| X | Clinicians documented Suicide Prevention Safety Plans that contained the following required elements:<br>• Identification of warning signs<br>• Identification of internal coping strategies<br>• Identification of contact numbers of family or friends for support<br>• Identification of professional agencies<br>• Assessment of available lethal means and how to keep the environment safe | • Sixteen of the 39 safety plans (41 percent) lacked documentation of the identification of contact numbers of family or friends for support.<br>• Nine of the 39 safety plans (23 percent) lacked documentation of an assessment of available lethal means and how to keep the environment safe. | **9.** We recommended that clinicians include contact numbers of family or friends for support and an assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance. |
| | Clinicians documented that they gave patients and/or caregivers a copy of the safety plan. | | |
| X | The treatment team evaluated patients as follows:<br>• At least four times during the first 30 days after discharge<br>• Every 90 days to review Patient Record Flags | • Seven of the 38 applicable EHRs (18 percent) did not contain evidence that the treatment team reviewed patients' high-risk flags at least every 90 days. | **10.** We recommended that treatment teams review patients' high-risk flags at least every 90 days and that facility managers monitor compliance. |
| | The facility complied with any additional elements required by VHA or local policy. | | |

| Facility Profile (Amarillo/504) FY 2016 through March 2016[1] | |
|---|---|
| **Type of Organization** | Secondary |
| **Complexity Level** | 2-Medium complexity |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions** | $183.5 |
| **Number of:** | |
| • **Unique Patients** | 20,256 |
| • **Outpatient Visits** | 118,053 |
| • **Unique Employees**[2] | 896 |
| **Type and Number of Operating Beds (as of February 2016):** | |
| • **Hospital** | 44 |
| • **Community Living Center** | 120 |
| • **Domiciliary** | NA |
| **Average Daily Census (as of February 2016):** | |
| • **Hospital** | 18 |
| • **Community Living Center** | 98 |
| • **Domiciliary** | NA |
| **Number of Community Based Outpatient Clinics** | 4 |
| **Location(s)/Station Number(s)** | Lubbock/504BY<br>Clovis/504BZ<br>Childress/504GA<br>Dalhart/504HB |
| **Veterans Integrated Service Network Number** | 17 |

[1] All data is for FY 2016 through March 2016 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

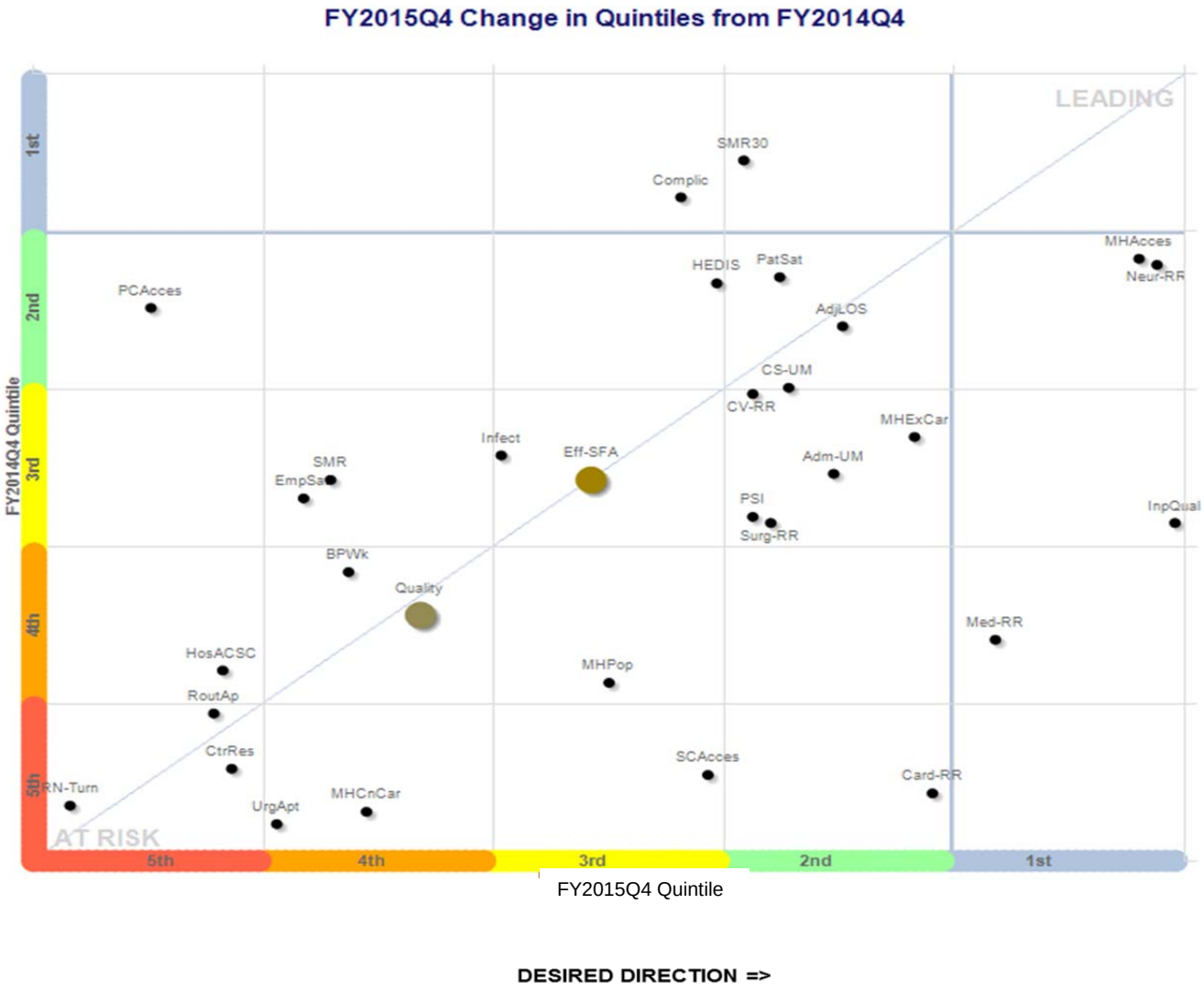
# Strategic Analytics for Improvement and Learning (SAIL)[3]




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

[3] Metric definitions follow the graphs.

# Scatter Chart




DESIRED DIRECTION =>

**NOTE**

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

# Metric Definitions

| Measure | Definition | Desired direction |
|---|---|---|
| ACSC Hospitalization | Ambulatory care sensitive condition hospitalizations (observed to expected ratio) | A lower value is better than a higher value |
| Adjusted LOS | Acute care risk adjusted length of stay | A lower value is better than a higher value |
| Best Place to Work | Overall satisfaction with job | A higher value is better than a lower value |
| Call Center Responsiveness | Average speed of call center responded to calls in seconds | A lower value is better than a higher value |
| Call Responsiveness | Call center speed in picking up calls and telephone abandonment rate | A lower value is better than a higher value |
| Complications | Acute care risk adjusted complication ratio | A lower value is better than a higher value |
| Efficiency | Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis) | A higher value is better than a lower value |
| Employee Satisfaction | Overall satisfaction with job | A higher value is better than a lower value |
| HC Assoc Infections | Health care associated infections | A lower value is better than a higher value |
| HEDIS | Outpatient performance measure (HEDIS) | A higher value is better than a lower value |
| MH Wait Time | MH wait time for new and established patients (top 50 clinics; FY13 and later) | A higher value is better than a lower value |
| MH Continuity Care | MH continuity of care (FY14Q3 and later) | MH Continuity Care |
| MH Exp of Care | MH experience of care (FY14Q3 and later) | A higher value is better than a lower value |
| MH Popu Coverage | MH population coverage (FY14Q3 and later) | A higher value is better than a lower value |
| Oryx | Inpatient performance measure (ORYX) | A higher value is better than a lower value |
| Primary Care Wait Time | Primary care wait time for new and established patients (top 50 clinics; FY13 and later) | A higher value is better than a lower value |
| PSI | Patient safety indicator (observed to expected ratio) | A lower value is better than a higher value |
| Pt Satisfaction | Overall rating of hospital stay (inpatient only) | A higher value is better than a lower value |
| RN Turnover | Registered nurse turnover rate | A lower value is better than a higher value |
| RSMR-AMI | 30-day risk standardized mortality rate for acute myocardial infarction | A lower value is better than a higher value |
| RSMR-CHF | 30-day risk standardized mortality rate for congestive heart failure | A lower value is better than a higher value |
| RSMR-Pneumonia | 30-day risk standardized mortality rate for pneumonia | A lower value is better than a higher value |
| RSRR-AMI | 30-day risk standardized readmission rate for acute myocardial infarction | A lower value is better than a higher value |
| RSRR-CHF | 30-day risk standardized readmission rate for congestive heart failure | A lower value is better than a higher value |
| RSRR-Pneumonia | 30-day risk standardized readmission rate for pneumonia | A lower value is better than a higher value |
| SMR | Acute care in-hospital standardized mortality ratio | A lower value is better than a higher value |
| SMR30 | Acute care 30-day standardized mortality ratio | A lower value is better than a higher value |
| Specialty Care Wait Time | Specialty care wait time for new and established patients (top 50 clinics; FY13 and later) | A higher value is better than a lower value |

# Veterans Integrated Service Network Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** May 19, 2016

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

**Subject:** **CAP Review of the Amarillo VA Health Care System, Amarillo, TX**

**To:** Director, San Diego Office of Healthcare Inspections (54SD)

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

1. Thank you for allowing me to respond to this CAP Review for the Amarillo VA Health Care System.

2. I have reviewed and concur with the findings of this report. Specific corrective actions have been provided for the recommendations.

3. Should you have any questions, please contact Denise Elliott, VISN 17 Quality Management Officer at 817-385-3734.

for Joseph Dalpiaz

Network Director

# Facility Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** May 19, 2016

**From:** Director, Amarillo VA Health Care System (504/00)

**Subject:** **CAP Review of the Amarillo VA Health Care System, Amarillo, TX**

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

1. On behalf of AVAHCS, I would like to take this opportunity to express my sincere appreciation to the Office of the Inspector General (OIG), Combined Assessment Program (CAP) review team for their professionalism, consultative approach, and excellent feedback provided to our staff during the review conducted the week of March 21, 2016.

2. The recommendations were reviewed and I concur with the findings. Our comments and implementation plan are delineated below. Corrective action plans have been developed or executed for continual monitoring. AVAHCS welcomes the external perspective provided, which we will utilize to further strengthen the quality of care we provide to our Veterans.

3. Should you have questions or require additional information, please do not hesitate to contact Leslie Whitaker, Chief of Quality, Safety, and Value at 806-355-9703, extension 7007.

Michael L. Kiefer, MHA, FACHE

Director, Amarillo VA Health Care System (504/00)

# Comments to OIG's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that the facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.

Concur

Target date for completion: June 7, 2016

Facility response: The FPPE [Focused Professional Practice Evaluation] trigger process was implemented in January, 2016, and applied to the first physician after that date. The physician started on March 20, 2016 and will complete the FPPE review period in May, 2016. The final review of FPPE and determination of acceptance or trigger for additional review is scheduled to be presented to the June 7, 2016, Credentialing committee meeting, which was the first time the new process was implemented. The process will be ongoing for all new providers.

**Recommendation 2.** We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Chief of Staff will monitor implementation of improvement actions recommended by the Peer Review Committee to ensure that all follow up is completed appropriately and timely. A standing agenda item has been added to the Peer Review Committee to give a monthly report by service of any outstanding follow up. Services are recognized when they are compliant, and the Chief of Staff follows up on those services that have outstanding items. This new process began at the May 2016 Peer Review Committee meeting. The Chief of Staff is notified of non-compliant items with each Peer Review Committee meeting and will follow up with appropriate service chief(s). Staff trending will be used to identify further actions. Progress of report actions and compliance monitoring will be reported at least monthly to MEB and Continuous Readiness committees, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

**Recommendation 3.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: In November 2015, the Utilization Management (UM) employee was aligned under the Quality, Safety, Value (QSV) service. A more intense focus was placed on the PUMA [Physician Utilization Management Advisor] process, and physician reviewers received additional education. PUMA response rates will be monitored until a target of 90% compliance has been sustained for 3 consecutive months. When noncompliance is identified, the applicable staff member is notified, as well as reported to Chief of Staff to follow-up with the respective PUMA. Staff trending will be used to identify further actions. Compliance monitoring will be reported to Continuous Readiness committees, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

**Recommendation 4.** We recommended that designated employees follow the facility policy for identification of individuals entering the facility after normal business hours and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: Chief, Police Services is currently reviewing and revising the facility policy to determine the appropriate approach for identification of individuals entering the facility after normal business hours. Until the policy is revised, the Chief of Police Service has educated employees responsible for keeping the afterhours log and on the appropriate form to use, as well as the importance of its use. Each week the Chief of Police ensures that the correct form is in use and that individuals are signing upon entering the facility after hours. Progress of actions is to be reported at least monthly to Continuous Readiness committee, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

**Recommendation 5.** We recommended that facility managers ensure medical waste/biohazard containers are properly secured and monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: In the two of five patient care areas (ED [Emergency Department] and ICU [intensive care unit]) – the storage area with medical waste/biohazard containers are stored, the door is now locked. Weekly rounds will occur to ensure compliance with the appropriate security. If noncompliance is found, the door will be

re-locked and education will be provided to the staff on shift at that time. Progress of actions will be reported at least monthly to Continuous Readiness committees, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability. In the dental clinic, a risk assessment was performed that included the Infection Control, Sterile Processing, and Dental staff to determine how to minimize risks related to hazardous materials and waste. Since access to the area is difficult for Dental staff that are carrying dirty equipment and the risk is greater to have to unlock the door, the risk reduction action was to move the container to a secure area where patients/families do not go. The risk assessment revealed that there was more risk to lock the door than to leave unlocked, but to place the container strategically in an area that is away from public access. Compliance will be monitored until a target of 90% has been sustained for 3 consecutive months.

**Recommendation 6.** We recommended that facility managers ensure employees perform and consistently document monthly cleaning of walls and light fixtures in all compounding areas and monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: The Chief of EMS educated current employees (100%) on 5/3/16. Their orientation checklist will be updated by 5/30/16 to ensure appropriate training of new staff. The Chief, Pharmacy Service is to monitor EMS logs weekly/monthly to ensure compliance with cleaning of compounding areas. When noncompliance is identified, the staff member is notified and immediate correction is made. Staff trending will be used to identify further actions. Progress of actions reported at least monthly to Continuous Readiness committees then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability. Compliance will be monitored until a target of 90% has been sustained for 3 consecutive months.

**Recommendation 7.** We recommended that sending nurses document transfer assessments and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Within the organization, an intra-ward transfer sending note and transfer receiving note template will be developed to include an assessment section that will require completion by the sending and receiving nurses, as applicable. Once the templated note is developed and available in CPRS, nurses will be educated on the new documentation expectations and process with a go-live date of no later than July 1, 2016. After that date, chart audits will be conducted to ensure that the goal of 90% or greater compliance is achieved for a minimum of 3 months. Progress of action items and chart audit results will be reported at least monthly to Continuous Readiness Committees, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

**Recommendation 8.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: TMS training requirement was changed to include all clinicians. Education Service will review TMS records monthly to ensure compliance with Suicide Risk Management Training for Clinicians. These reports will include when the 90 days is approaching to help ensure timeliness. When noncompliance is identified, that employee's supervisor will be notified and provided with a deadline for completion. Staff trending will be used to identify further actions when appropriate. Progress of actions will be reported at least monthly to Continuous Readiness committees, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability. Compliance will be monitored until a target of 90% has been sustained for 3 consecutive months.

**Recommendation 9.** We recommended that clinicians include contact numbers of family or friends for support and an assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: Chief, Mental Health (MH) changed the Mental Health Service policy to require all new cases to have a safety plan that includes documentation of identification of contact numbers of family or friends for support, as well as an assessment of available lethal means and how to keep the environment safe. A refresher course from TMS was assigned to MH staff that includes policy changes and staff expectations. 100% of staff have completed the refresher course. MH staff were also trained on appropriate documentation in electronic health record during April 21, 2016, staff meeting. Chart audits will be performed monthly to ensure compliance. 30 records per month will be randomly selected to audit with an expected goal of 90% compliance sustained for at least 3 consecutive months. When noncompliance is identified, the staff member is notified. Staff trending will be used to identify further actions. Progress of actions reported at least monthly to Continuous Readiness committees, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

**Recommendation 10.** We recommended that treatment teams review patients' high-risk flags at least every 90 days and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: Suicide Prevention Coordinator now runs a Behavioral Flag Report and reviews with the treatment team at least every 90 days. Chart audits performed monthly to ensure compliance. When noncompliance is identified, the staff member is notified. Staff trending will be used to identify further actions. Progress of actions reported at least monthly to Continuous Readiness committees, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability. Compliance will be monitored until a target of 90% has been sustained for 3 consecutive months.

# Office of Inspector General
# Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the OIG at (202) 461-4720. |
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# Report Distribution

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

# Endnotes

[a] The references used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] The references used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] The references used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] The references used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.