



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

Office of Healthcare Inspections

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**Clinical Assessment Program
Review of the
El Paso VA Health Care System
El Paso, Texas**

July 17, 2017

Washington, DC 20420

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Glossary

| | |
|----------|--------------------------------|
| CAP | Clinical Assessment Program |
| CNH | community nursing home |
| EHR | electronic health record |
| EOC | environment of care |
| facility | El Paso VA Health Care System |
| FY | fiscal year |
| MH | mental health |
| NA | not applicable |
| NM | not met |
| OIG | Office of Inspector General |
| PC | primary care |
| POCT | point-of-care testing |
| PTSD | post-traumatic stress disorder |
| QSV | quality, safety, and value |
| RME | reusable medical equipment |
| SPS | Sterile Processing Service |
| VHA | Veterans Health Administration |

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Executive Summary

Purpose and Objectives: The review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the El Paso VA Health Care System. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Diagnostic Care; Community Nursing Home Oversight; Management of Disruptive/Violent Behavior; and Post-Traumatic Stress Disorder Care. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic reviews and provided crime awareness briefings.

Results: We conducted the review during the week of February 6, 2017, and identified certain system weaknesses in credentialing and privileging, patient safety, and root cause analysis; anticoagulation policies and processes; Community Nursing Home Oversight Committee membership; disruptive/violent behavior management training; and suicide risk assessments for patients who screened positive for post-traumatic stress disorder.

Review Impact: As a result of the findings, we could not gain reasonable assurance that:

1. The facility has an effective process for reviewing Ongoing Professional Practice Evaluation data.
2. The Patient Safety Manager enters all reported patient incidents into the required database.
3. The facility takes actions in root cause analyses when data analyses indicate problems or opportunities for improvement.
4. The facility has comprehensive policies and processes for anticoagulation management.
5. The Community Nursing Home Oversight Committee includes all required members.
6. The facility ensures employees receive training to reduce and prevent disruptive behaviors.
7. Patients with positive post-traumatic stress disorder screens receive suicide risk assessments.

Recommendations: We made recommendations in the following five review areas.

Quality, Safety, and Value – Ensure that:

- Ongoing Professional Practice Evaluation data is reviewed quarterly.
- The Patient Safety Manager consistently enters all reported patient incidents into the WEBSPOOT database.
- Actions are taken and evaluated for effectiveness when data analyses indicate problems or opportunities for improvement in root cause analyses.

Medication Management: Anticoagulation Therapy – Ensure that:

- The policy for anticoagulation management is revised to include an anticoagulation quality assurance program and that processes are developed and implemented to address noncompliance with the treatment plan.
- Ways to minimize the risk of incorrect tablet strength dosing errors are defined.
- Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications.

Community Nursing Home Oversight – Ensure that:

- The Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.

Management of Disruptive/Violent Behavior – Ensure that:

- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Post-Traumatic Stress Disorder Care – Ensure that:

- Acceptable providers perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 35–41, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



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Purpose and Objectives

Purpose

This CAP review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the facility.

Objectives

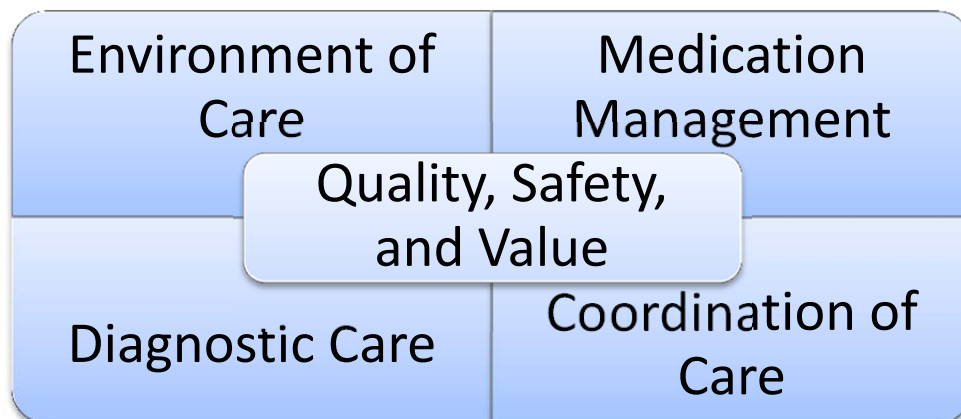
CAP reviews are one element of OIG’s efforts to ensure that our Nation’s veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care.

OIG also evaluates processes that are high risk and problem-prone—CNH Oversight, Management of Disruptive/Violent Behavior, and PTSD Care—and follows up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and PC Clinic reviews. Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

Background

We evaluate key aspects of clinical care delivery in a variety of primary/specialty care and inpatient/outpatient settings. These aspects include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care (see Figure 1 below).

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

Quality, Safety, and Value

According to the Institute of Medicine (now the National Academy of Medicine), there are six important components of a health care system that provides high quality care to individuals. The system:

1. Is safe (free from accidental injury) for all patients, in all processes, all the time.
2. Provides care that is effective (care that, wherever possible, is based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcome).
3. Is patient-centered. This concept includes respect for patients' values and preferences; coordination and integration of care; information, communication, and education; physical comfort; and involvement of family and friends.
4. Delivers care in a timely manner (without long waits that are wasteful and often anxiety-provoking).
5. Is efficient (uses resources to obtain the best value for the money spent).
6. Is equitable (bases care on an individual's needs and not on personal characteristics—such as gender, race, or insurance status—that are unrelated to the patient's condition or to the reason for seeking care).¹

VA states that one of its strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.²

Environment of Care

All facilities face risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The EOC is made up of three basic elements: (1) the building or space; (2) equipment used to support patient care; and (3) people who enter the environment.³

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental features, such as the

¹ Teleki SS, Damberg, CL, Reville RT. *Quality of Health Care: What Is It, Why Is It Important, and How Can It Be Improved in California's Workers Compensation Programs?* Santa Monica: RAND Corporation; May 2003 Quality and Workers' Compensation Working Draft.

² Department of Veterans Affairs, VHA. *Blueprint for Excellence*. September 2014.

³ The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition®*: Joint Commission Resources; July 2016: Environment of Care (EC).

placement of doorways, flooring type, and the location of furniture, can contribute to patient falls and associated injuries.⁴

Medication Management

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The Institute of Medicine (now the National Academy of Medicine) noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.^{5,6}

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. In many cases, diagnostic testing can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.⁷

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.⁸

⁴ Joseph A, Malone EB. *The Physical Environment: An Often Unconsidered Patient Safety Tool*. Agency for Healthcare Research and Quality. Patient Safety Network; October 2012.

⁵ Patient-Centered Primary Care Collaborative. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide*. 2nd ed; June 2012.

⁶ The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition®*: Joint Commission Resources; July 2016: Medication Management (MM).

⁷ Committee on Diagnostic Error in Health Care. Balogh EP, Miller BT, Ball JR, eds. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015: Chap. 2.

⁸ Department of Veterans Affairs. Patient Care Services. Diagnostic Services. <http://www.patientcare.va.gov/diagnosticervices.asp>. Accessed September 21, 2016.

High-Risk and Problem-Prone Health Care Processes

Health care leaders must give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.⁹ “Specifically, they are responsible for identifying high-risk areas that could cause harm to patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that do occur. But of all of their responsibilities, one of the most important is focusing on improving patient safety.”¹⁰

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.¹¹ These CNHs may be within close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This involves annual reviews and monthly patient visits unless otherwise specified.¹²

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined, and many of these assaults and violent acts are perpetrated by patients.¹³ Management of disruptive/violent behavior is the process of reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.¹⁴ VHA has a directive that addresses the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility; however, staff training deadlines have been postponed several times.

PTSD is a disorder that may occur “...following exposure to an extreme traumatic stressor involving direct personal experience.”¹⁵ FYs 2010 through 2015, more than 1 million patients with a primary or secondary diagnosis of PTSD received MH care at VA medical centers and clinics. During FY 2016, VA MH clinicians diagnosed and treated more than 100,000 additional patients who had not been previously diagnosed with PTSD.¹⁶ Because of the risks involved if this condition is not diagnosed and

⁹ The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition®*: Joint Commission Resources; July 2016: Leadership (LD) Accreditation Requirements, LD.04.04.01, EP2.

¹⁰ Bickmore, AM. Streamlining the Risk Management Process in Healthcare to Improve Workflow and Increase Patient Safety, *HealthCatalyst*, <https://www.healthcatalyst.com/streamlining-risk-management-process-healthcare>.

¹¹ VA Corporate Data Warehouse. Accessed October 31, 2016.

¹² VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

¹³ U.S. Bureau of Labor Statistics. Janocha JA, Smith RT. *Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003–07*. <http://www.bls.gov/opub/mlr/cwc/workplace-safety-and-health-in-the-health-care-and-social-assistance-industry-2003-07.pdf>. August 30, 2010. Accessed October 28, 2016.

¹⁴ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

¹⁵ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.

¹⁶ VA Corporate Data Warehouse. Accessed November 1, 2016.

treated, clinical employees need to screen patients for PTSD, in accordance with requirements, when they present for care.

Scope

To evaluate for compliance with requirements related to patient care quality, clinical functions, and the EOC, we physically inspected selected areas, discussed processes and validated findings with managers and employees, and reviewed clinical and administrative records. The review covered the following four aspects of clinical care.

- Quality, Safety, and Value
- Environment of Care
- Medication Management: Anticoagulation Therapy
- Diagnostic Care: Point-of-Care Testing

We also evaluated three additional review areas because of inherent risks and potential vulnerabilities.

- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior
- Post-Traumatic Stress Disorder Care

We list the review criteria for each of the review areas in the topic checklists.

The review covered operations for FY 2015, FY 2016, and FY 2017 through February 10, 2017, and inspectors conducted the reviews 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 Combined Assessment Program report (*Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas, Report No. 13-03651-42, January 15, 2014*) and Community Based Outpatient Clinic report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at El Paso VA Health Care System, El Paso, Texas, Report No. 14-00241-128, April 24, 2014*).

We presented crime awareness briefings for 291 employees. These briefings covered procedures for reporting suspected criminal activity to 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 196 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 OIG to monitor until the facility implements corrective actions. When issues and concerns outside the scope of this CAP review come to our attention, they can be referred for further review separate from this report.

Reported Accomplishments

Clinical Team Training

In May 2015, the facility initiated clinical team training with the VA National Center for Patient Safety. The National Center for Patient Safety newsletter recognized the first project at the Las Cruces outpatient clinic and also included aspects of the project in a paper on human factors engineering it authored. This training led to increased veteran walk-in access, employee satisfaction, and completion of reminder screenings for alcohol and tobacco use, depression, and PTSD. In the first 2 months, the amount of time the clinic manager spent handling patient complaints decreased from 50 percent of the work day to approximately 10 percent. One year after implementation, employee satisfaction with the patient walk-in process had increased from 36 percent to 90 percent being either satisfied or very satisfied. Additionally, the completion rate of the reminder screenings for major risk factors increased an overall average of 12 percent.

Pharmacy Diffusion of Excellence Project

The pharmacy Diffusion of Excellence project was initiated in April 2016 and was designed to increase access to PC and chronic disease management clinics by integrating the clinical pharmacy specialists into the Patient Aligned Care Teams to better leverage their scope of practice. This led to 15 minutes being saved for each new patient appointment. As a result, 13.25 provider Patient Aligned Care Team hours were made available. The project also facilitated 76 percent of the patients to be seen by a Center for Patient Safety provider instead of a Patient Aligned Care Team provider thereby opening 13 new appointments or 6.5 hours of access in the first 4 weeks of implementation.

Results and Recommendations

Quality, Safety, and Value

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.^a VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. Many QSV activities are required by VHA directives, accreditation standards, and Federal regulations. Public Law 100-322 mandates VA's OIG to oversee VHA quality improvement programs at every level. This review focuses on the following program areas.

- Senior-level committee or group with responsibility for QSV/performance improvement
- Protected peer review
- Credentialing and privileging
- Patient safety

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 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.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

| 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. <ul style="list-style-type: none"> • The committee routinely reviewed aggregated data. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|---|---|--|
| X | <p>Credentialing and privileging processes met selected requirements:</p> <ul style="list-style-type: none"> • Facility policy/by-laws specified a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. | <ul style="list-style-type: none"> • None of the 25 profiles contained evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data quarterly. | <p>1. We recommended that facility clinical managers review Ongoing Professional Practice Evaluation data quarterly and that facility managers monitor compliance.</p> |
| | <p>Protected peer reviews met selected requirements:</p> <ul style="list-style-type: none"> • 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. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions. | | |
| NA | <p>Utilization management met selected requirements:</p> <ul style="list-style-type: none"> • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|--|---|--|
| X | Patient safety met selected requirements: <ul style="list-style-type: none"> • The Patient Safety Manager entered all reported patient incidents into the WEBSPOt database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders. | <ul style="list-style-type: none"> • The Patient Safety Manager did not enter 53 of 258 patient incidents reported in FY 2016 into the WEBSPOt database. | <p>2. We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOt database and that facility managers monitor compliance.</p> |
| X | For patient safety activities where issues were identified and root cause analysis performed, the facility took actions and evaluated them for effectiveness. | <ul style="list-style-type: none"> • The facility did not consistently take actions and evaluate them for effectiveness in root cause analyses. | <p>3. We recommended that the facility consistently take actions when data analyses indicated problems or opportunities for improvement and evaluate them for effectiveness in root cause analyses and that facility managers monitor compliance.</p> |
| | Overall, senior managers actively participated in QSV activities. | | |

Environment of Care

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 SPS.^b

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish a systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. We selected the hemodialysis unit and SPS as special emphasis areas due to the increased potential for exposure to infectious agents inherent to hemodialysis and procedures using RME. Hemodialysis patients are at higher risk for infections for various reasons, including that hemodialysis requires vascular access for prolonged periods of time and that opportunities exist for transmission of infectious agents when multiple patients receive dialysis concurrently. RME is intended for repeated use on different patients after being reprocessed through cleaning, disinfection, and/or sterilization. Patients undergoing procedures using RME are at higher risk of exposure to infectious agents if RME is not properly reprocessed.

We inspected the ambulatory surgery unit; SPS; physical therapy; specialty clinic-6; the women’s health, cardiology, and MH clinics; and three PC clinics. We also inspected the canteen and the Las Cruces outpatient clinic. Additionally, we reviewed relevant documents and interviewed key employees and managers. 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.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

| 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. | | |

| NM | Areas Reviewed for General EOC (continued) | Findings | Recommendations |
|-------------------------------|--|----------|-----------------|
| | The facility had established a procedure for cleaning equipment between patients. | | |
| | The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques. | | |
| | The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements. | | |
| | The facility met general safety requirements. | | |
| | The facility met environmental cleanliness requirements. | | |
| Areas Reviewed for SPS | | | |
| | The facility had a policy for cleaning, disinfecting, and sterilizing RME. | | |
| NA | The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use. | | |
| NA | The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results. | | |
| NA | Selected SPS employees had evidence of the following for selected RME: <ul style="list-style-type: none"> • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year | | |
| | The facility met infection prevention requirements in SPS areas. | | |

| NM | Areas Reviewed for SPS (continued) | Findings | Recommendations |
|----|---|----------|-----------------|
| NA | Standard operating procedures for selected RME were located in the area where reprocessing occurred. | | |
| | SPS employees checked eyewash stations in SPS areas weekly. | | |
| | SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals. | | |
| | Areas Reviewed for the Hemodialysis Unit | | |
| NA | The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy. | | |
| NA | Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months. | | |
| NA | The facility met environmental safety requirements on the hemodialysis unit. | | |
| NA | The facility met infection prevention requirements on the hemodialysis unit. | | |
| NA | The facility met medication safety and security requirements on the hemodialysis unit. | | |
| NA | The facility met privacy requirements on the hemodialysis unit. | | |

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.^c During FY 2016, more than 482,000 veterans received an anticoagulant. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism¹⁷ in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission’s National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, “...anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance.”

We reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 26 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 3. Medication Management: Anticoagulation Therapy Areas Reviewed, Findings, and Recommendations

| NM | Areas Reviewed | Findings | Recommendations |
|----|--|--|---|
| X | The facility had policies and processes for anticoagulation management that included required content. | <ul style="list-style-type: none"> • Facility policy did not include an anticoagulation quality assurance program. • The facility did not have a process to address noncompliance with the treatment plan. | <p>4. We recommended that the facility revise the policy for anticoagulation management to include an anticoagulation quality assurance program.</p> <p>5. We recommended that the facility develop and implement a process to address noncompliance with the treatment plan.</p> |

¹⁷ Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|--|---|---|
| | The facility used algorithms, protocols or standardized care processes for the: <ul style="list-style-type: none"> • Initiation and maintenance of warfarin • Management of anticoagulants before, during, and after procedures • Use of weight-based, unfractionated heparin | | |
| | The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours. | | |
| | The facility designated a physician as the anticoagulation program champion. | | |
| X | The facility defined ways to minimize the risk of incorrect tablet strength dosing errors. | <ul style="list-style-type: none"> • The facility had not defined ways to minimize the risk of incorrect tablet strength dosing errors. | 6. We recommended that the facility define ways to minimize the risk of incorrect tablet strength dosing errors. |
| | The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee. | | |
| X | Clinicians provided transition follow-up for inpatients with newly prescribed anticoagulant medications and education specific to the new anticoagulant to both inpatients and outpatients. | <ul style="list-style-type: none"> • Nine of the 26 EHRs did not contain evidence that patients received education specific to the newly prescribed anticoagulant. | 7. We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance. |
| | Clinicians obtained required laboratory tests: <ul style="list-style-type: none"> • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|---|----------|-----------------|
| | When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant. | | |
| | The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy. | | |

Diagnostic Care: Point-of-Care Testing

The purpose of this review was to evaluate the facility’s glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.^d The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient’s bedside, the patient’s home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and pro-thrombin time.

All laboratory testing performed in VHA facilities must adhere to quality testing practices. These practices include annual competency assessment and quality control testing. Failure to implement and comply with regulatory standards and quality testing practices can jeopardize patient safety and place VHA facilities at risk. Erroneous results can lead to inaccurate diagnoses, inappropriate medical treatment, and poor patient outcomes.¹⁸

We reviewed relevant documents, the EHRs of 23 outpatients who underwent POCT for blood glucose from July 1, 2015 through June 30, 2016, and the annual competency assessments of 10 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the women’s health, PC, ambulatory surgery, and MH clinics and the Las Cruces outpatient clinic to assess compliance with manufacturers’ maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 4. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

| NM | Areas Reviewed | Findings | Recommendations |
|----|---|----------|-----------------|
| | The facility had a policy delineating requirements for the POCT program and required oversight by the Chief of Pathology and Laboratory Medicine Service. | | |
| | The facility had a designated POCT/Ancillary Testing Coordinator. | | |
| | The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory. | | |

¹⁸ The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|---|----------|-----------------|
| | The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually. | | |
| | The facility required documentation of POCT results in the EHR. | | |
| | A regulatory agency accredited the facility's POCT program. | | |
| | Clinicians documented test results in the EHR. | | |
| | Clinicians initiated appropriate clinical action and follow-up for test results. | | |
| | The facility had POCT procedure manuals readily available to employees. | | |
| | Quality control testing solutions/reagents and glucose test strips were current (not expired). | | |
| | The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations. | | |
| | Glucometers were clean. | | |

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.⁹ Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.¹⁹ Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents and the results from CNH annual reviews completed from July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. 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.

Checklist 5. CNH Oversight Areas Reviewed, Findings, and Recommendations

| NM | Areas Reviewed | Findings | Recommendations |
|----|---|---|---|
| X | The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines. | <ul style="list-style-type: none"> The facility's CNH Oversight Committee did not include a representative from the medical staff. | 8. We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines. |
| | The facility integrated the CNH Program into its quality improvement program. | | |
| NA | The facility documented a hand-off for patients placed in CNHs outside of its catchment area. | | |
| | The CNH Review Team completed CNH annual reviews. | | |
| | When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation. | | |

¹⁹ VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|-----------|--|-----------------|------------------------|
| NA | Social workers and registered nurses documented clinical visits that alternated on a cyclical basis. | | |

Management of Disruptive/Violent Behavior

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of disruptive and violent behavior.^f VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety. In addition, Public Law 112-154, section 106 directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.

We reviewed relevant documents, the EHRs of 42 patients who exhibited disruptive or violent behavior, 3 Reports of Contact from violent/disruptive patient/employee/other (visitor) incidents that occurred during the 12-month period July 1, 2015 through June 30, 2016, and the training records of 25 recently hired employees who worked in areas at low or moderate risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 6. Management of Disruptive/Violent Behavior Areas Reviewed, Findings, and Recommendations

| NM | Areas Reviewed | Findings | Recommendations |
|----|--|----------|-----------------|
| | The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior. | | |
| | The facility conducted an annual Workplace Behavioral Risk Assessment. | | |
| | The facility had implemented: <ul style="list-style-type: none"> • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system | | |
| | The facility collected and analyzed disruptive or violent behavior incidents data. | | |
| | The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|---|--|---|
| | <p>Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including:</p> <ul style="list-style-type: none"> • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction | | |
| | <p>When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.</p> | | |
| | <p>The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.</p> | | |
| X | <p>The facility had a security training plan for employees at all risk levels.</p> <ul style="list-style-type: none"> • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire. | <ul style="list-style-type: none"> • Seven of the 25 employee training records did not contain documentation of Level 1 training within 90 days of hire. • Twenty-four of the 25 employee training records did not contain documentation of the training required for their assigned risk area within 90 days of hire. | <p>9. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.</p> |

Post-Traumatic Stress Disorder Care

The purpose of this review was to assess whether the facility complied with selected VHA requirements for PTSD follow-up in the outpatient setting.⁹ PTSD is a disorder that may occur "...following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."²⁰

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed. For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. VHA requires that:

- Every new patient receive PTSD screening that is then repeated every year for the first 5 years post-separation and every 5 years thereafter unless there is a clinical need to screen earlier.
- If a patient's PTSD screen is positive, an acceptable provider evaluates treatment needs and assesses for suicide risk.
- If the provider determines a need for treatment, there is evidence of referral and coordination of care.

We reviewed relevant documents and the EHRs of 35 randomly selected outpatients who had a positive PTSD screen from July 1, 2015 through June 30, 2016. We also interviewed key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 7. PTSD Care Areas Reviewed, Findings, and Recommendations

| NM | Areas Reviewed | Findings | Recommendations |
|----|--|--|--|
| X | Each patient with a positive PTSD screen received a suicide risk assessment. | <ul style="list-style-type: none"> • Ten of the 35 patients (29 percent) did not receive a suicide risk assessment. | 10. We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens. |
| | Suicide risk assessments for patients with positive PTSD screens were completed by acceptable providers. | | |

²⁰ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|---|----------|-----------------|
| | Acceptable providers established plans of care and disposition for patients with positive PTSD screens. | | |
| | Acceptable providers offered further diagnostic evaluations to patients with positive PTSD screens. | | |
| | Providers completed diagnostic evaluations for patients with positive PTSD screens. | | |
| | Patients received MH treatment when applicable. | | |

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for El Paso (756) for FY 2016

| Profile Element | Facility Data |
|---|------------------|
| Veterans Integrated Service Network Number | 17 |
| Complexity Level | 3-Low complexity |
| Affiliated/Non-Affiliated | Affiliated |
| Total Medical Care Budget in Millions | \$209.6 |
| Number of: | |
| • Unique Patients | 34,151 |
| • Outpatient Visits | 339,029 |
| • Unique Employees²¹ | 723 |
| Type and Number of Operating Beds: | |
| • Acute | NA |
| • MH | NA |
| • Community Living Center | NA |
| • Domiciliary | NA |
| Average Daily Census: | |
| • Acute | NA |
| • MH | NA |
| • Community Living Center | NA |
| • Domiciliary | NA |

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

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

²¹ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles²²

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

Table 2. VA Outpatient Clinic Workload/Encounters²³ and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

| Location | Station No. | PC Workload/Encounters | MH Workload/Encounters | Specialty Care Services ²⁴ Provided | Diagnostic Services ²⁵ Provided | Ancillary Services ²⁶ Provided |
|----------------|-------------|------------------------|------------------------|--|--|---|
| Las Cruces, NM | 756GA | 9,916 | 5,104 | Dermatology Eye Neurology | EKG Laboratory & Pathology Radiology | Nutrition Pharmacy Social Work Weight Management |
| El Paso, TX | 756GB | 8,645 | 4,303 | Dermatology Eye | EKG | Pharmacy Weight Management |

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

²² Includes all outpatient clinics in the community that were in operation before February 15, 2016.

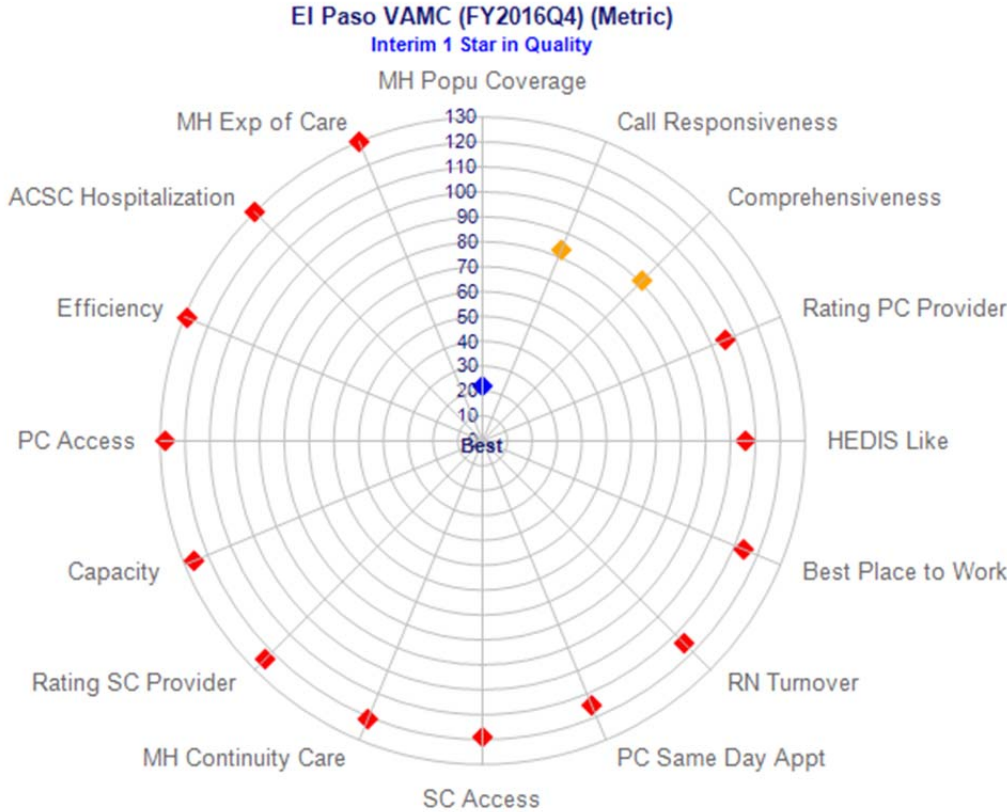
²³ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

²⁴ Specialty care services refer to non-PC and non-MH services provided by a physician.

²⁵ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

²⁶ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Strategic Analytics for Improvement and Learning (SAIL)²⁷



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

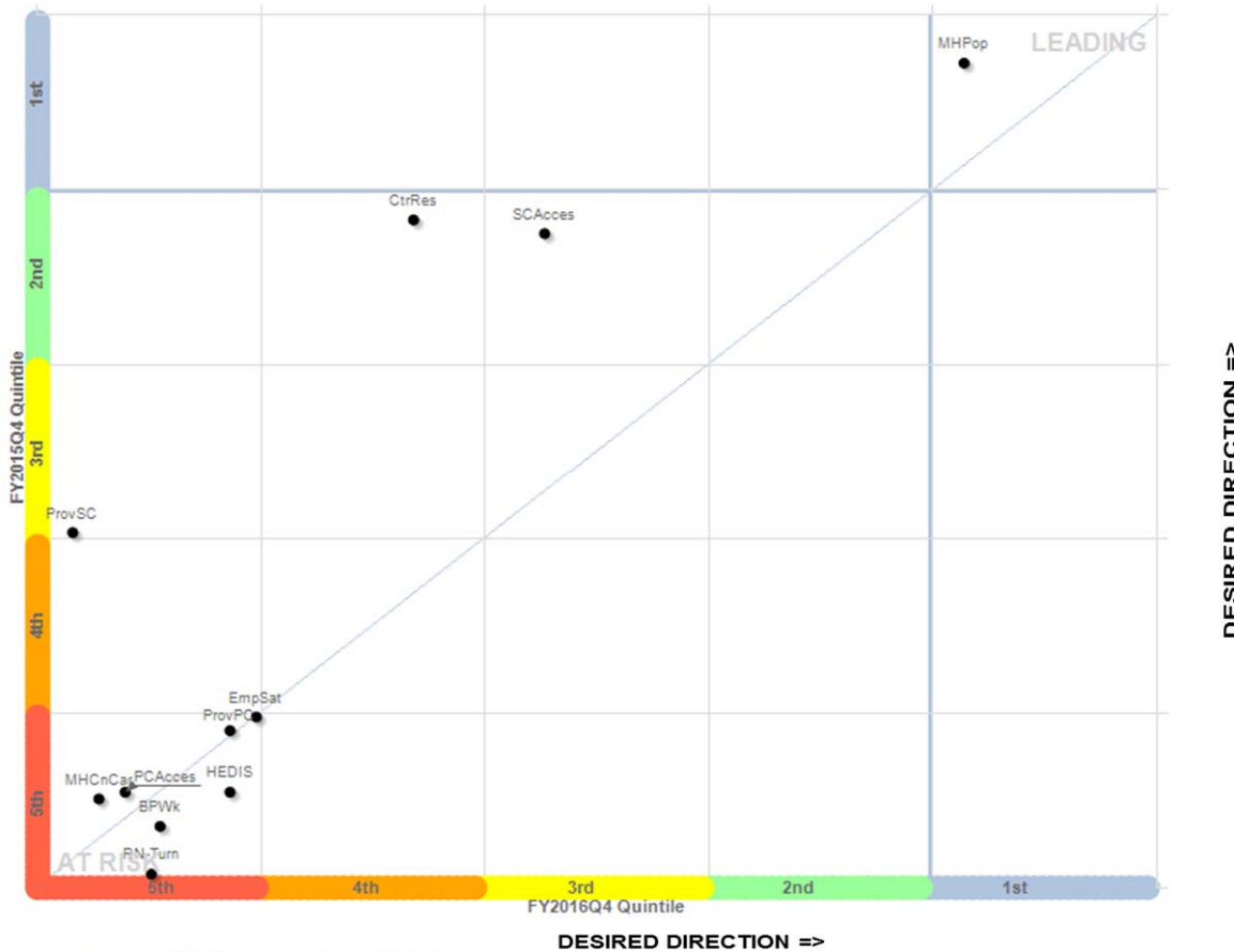
Source: VHA Support Service Center

Note: We did not assess VA’s data for accuracy or completeness.

²⁷ Metric definitions follow the graphs.

Scatter Chart

FY2016Q4 Change in Quintiles from FY2015Q4



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

Source: VHA Support Service Center

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

Metric Definitions^h

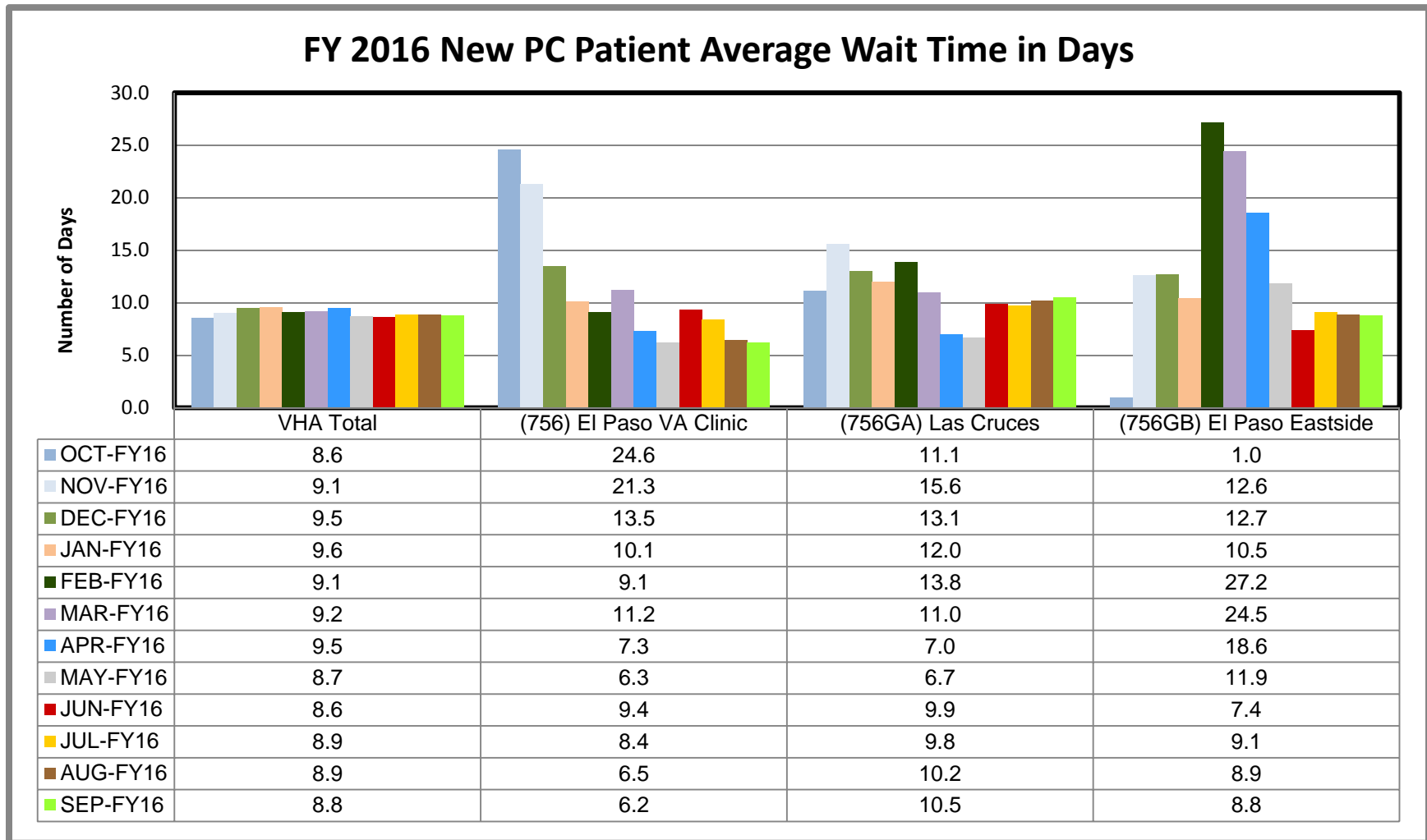
| Measure | Definition | Desired Direction |
|----------------------------|---|---|
| ACSC Hospitalization | Ambulatory care sensitive condition hospitalizations (observed to expected ratio) | A lower value is better than a higher value |
| Adjusted LOS | Acute care risk adjusted length of stay | A lower value is better than a higher value |
| Admit Reviews Met | % Acute Admission Reviews that meet InterQual criteria | A higher value is better than a lower 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 |
| Cont Stay Reviews Met | % 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 |
| 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 Like | Outpatient performance measure (HEDIS) | A higher value is better than a lower value |
| MH Wait Time | MH 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 | MH continuity of care (FY14Q3 and later) | A higher value is better than a lower value |
| 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 |
| 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 |
| 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 |
| Pt Satisfaction | 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 module) | 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 |

| Measure | Definition | Desired Direction |
|--------------------------|--|---|
| 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-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-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 |
| SC Routine Care Appt | Timeliness in getting a SC routine care appointment (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 |
| 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 |

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness

Patient Aligned Care Team Compass Metrics

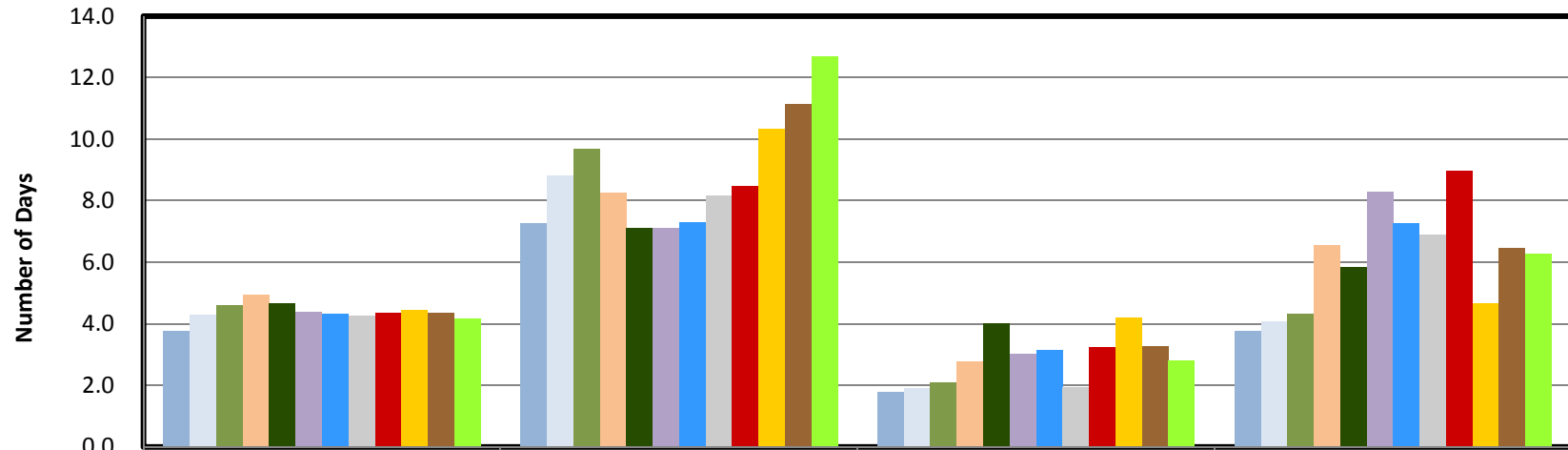


Source: VHA Support Service Center

Note: We did not assess VA’s data for accuracy or completeness.

Data Definition¹: The average number of calendar days between a new patient’s PC 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 FY 2015, this metric was calculated using the earliest possible create date.*

FY 2016 Established PC Patient Average Wait Time in Days



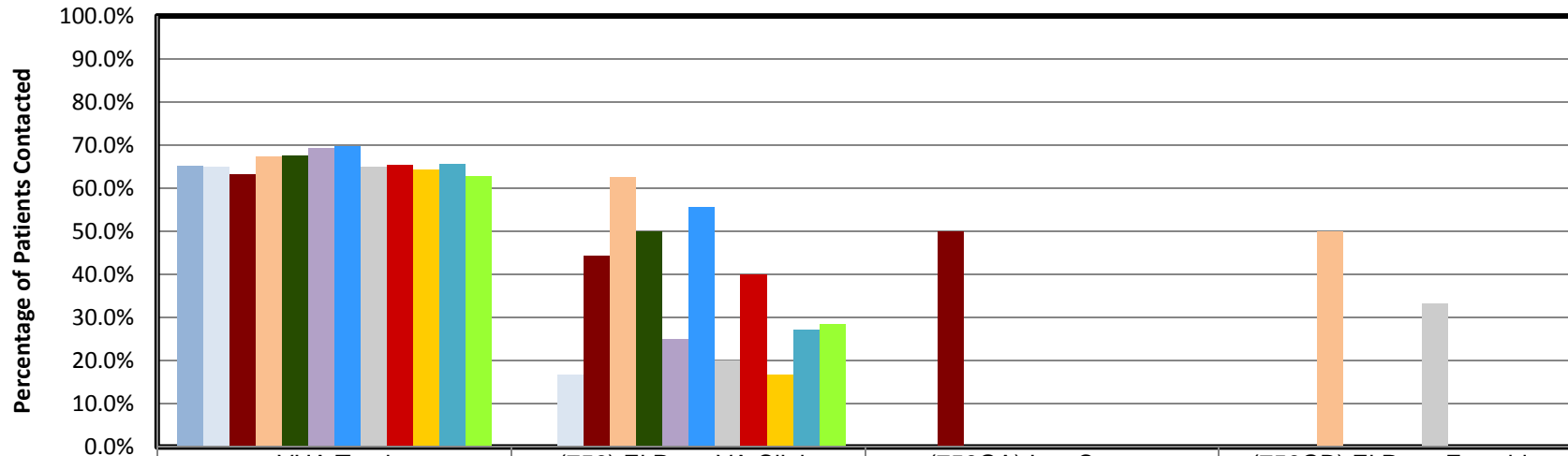
| | VHA Total | (756) El Paso VA Clinic | (756GA) Las Cruces | (756GB) El Paso Eastside |
|----------|-----------|-------------------------|--------------------|--------------------------|
| OCT-FY16 | 3.8 | 7.3 | 1.8 | 3.8 |
| NOV-FY16 | 4.3 | 8.8 | 1.9 | 4.1 |
| DEC-FY16 | 4.6 | 9.7 | 2.1 | 4.3 |
| JAN-FY16 | 4.9 | 8.3 | 2.8 | 6.5 |
| FEB-FY16 | 4.7 | 7.1 | 4.0 | 5.8 |
| MAR-FY16 | 4.4 | 7.1 | 3.0 | 8.3 |
| APR-FY16 | 4.3 | 7.3 | 3.1 | 7.3 |
| MAY-FY16 | 4.3 | 8.2 | 1.9 | 6.9 |
| JUN-FY16 | 4.4 | 8.5 | 3.2 | 9.0 |
| JUL-FY16 | 4.4 | 10.3 | 4.2 | 4.7 |
| AUG-FY16 | 4.3 | 11.1 | 3.3 | 6.5 |
| SEP-FY16 | 4.2 | 12.7 | 2.8 | 6.3 |

Source: VHA Support Service Center

Note: We did not assess VA’s data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient’s PC 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.

FY 2016 Team 2-Day Post Discharge Contact Ratio



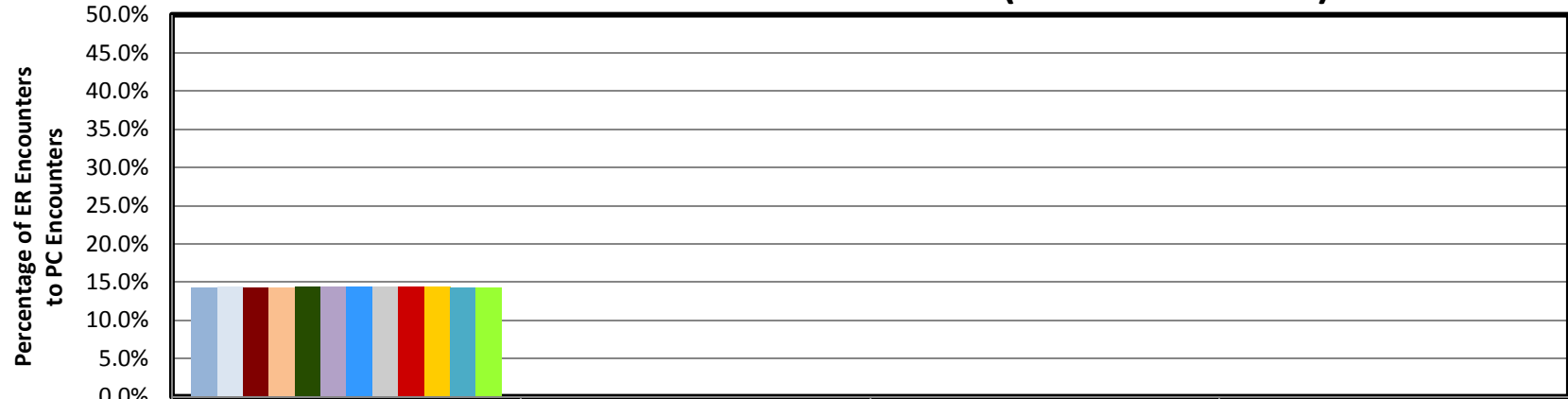
| | VHA Total | (756) El Paso VA Clinic | (756GA) Las Cruces | (756GB) El Paso Eastside |
|------------|-----------|-------------------------|--------------------|--------------------------|
| ■ OCT-FY16 | 65.2% | 0.0% | 0.0% | |
| ■ NOV-FY16 | 64.9% | 16.7% | 0.0% | 0.0% |
| ■ DEC-FY16 | 63.2% | 44.4% | 50.0% | |
| ■ JAN-FY16 | 67.5% | 62.5% | 0.0% | 50.0% |
| ■ FEB-FY16 | 67.6% | 50.0% | 0.0% | 0.0% |
| ■ MAR-FY16 | 69.2% | 25.0% | | 0.0% |
| ■ APR-FY16 | 69.7% | 55.6% | 0.0% | 0.0% |
| ■ MAY-FY16 | 65.0% | 20.0% | 0.0% | 33.3% |
| ■ JUN-FY16 | 65.5% | 40.0% | 0.0% | |
| ■ JUL-FY16 | 64.3% | 16.7% | | 0.0% |
| ■ AUG-FY16 | 65.7% | 27.3% | 0.0% | |
| ■ SEP-FY16 | 62.9% | 28.6% | 0.0% | |

Source: VHA Support Service Center

Note: We did not assess VA’s data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient’s team at the time of the patient’s discharge. Blank cells indicate the absence of reported data.

FY 2016 Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)



| | VHA Total | (756) El Paso VA Clinic | (756GA) Las Cruces | (756GB) El Paso Eastside |
|------------|-----------|-------------------------|--------------------|--------------------------|
| ■ OCT-FY16 | 14.3% | 0.0% | 0.0% | 0.0% |
| ■ NOV-FY16 | 14.4% | 0.0% | 0.0% | 0.0% |
| ■ DEC-FY16 | 14.3% | 0.0% | 0.0% | 0.0% |
| ■ JAN-FY16 | 14.3% | 0.0% | 0.0% | 0.0% |
| ■ FEB-FY16 | 14.4% | 0.0% | 0.0% | 0.0% |
| ■ MAR-FY16 | 14.4% | 0.0% | 0.0% | 0.0% |
| ■ APR-FY16 | 14.4% | 0.0% | 0.0% | 0.0% |
| ■ MAY-FY16 | 14.4% | 0.0% | 0.0% | 0.0% |
| ■ JUN-FY16 | 14.4% | 0.0% | 0.0% | 0.0% |
| ■ JUL-FY16 | 14.4% | 0.0% | 0.0% | 0.0% |
| ■ AUG-FY16 | 14.3% | 0.0% | 0.0% | 0.0% |
| ■ SEP-FY16 | 14.2% | 0.0% | 0.0% | 0.0% |

Source: VHA Support Service Center

Note: We did not assess VA’s data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

**Prior OIG Reports
December 1, 2014 through April 1, 2017**

Facility Reports

Healthcare Inspection – Review of Antimicrobial Stewardship Programs in VHA Facilities

12/15/2016 | 15-04247-111 | [Summary](#) | [Report](#)

Review of VHA's Patient-Centered Community Care (PC3) Provider Network Adequacy

9/29/2015 | 15-00718-507 | [Summary](#) | [Report](#)

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics

6/18/2015 | 15-01297-368 | [Summary](#) | [Report](#)

Healthcare Inspection - Review of Solo Physicians' Professional Practice Evaluations in Veterans Health Administration Facilities

6/3/2015 | 15-00911-362 | [Summary](#) | [Report](#)

An Analysis of Mental Health, Primary Care, and Specialty Care Productivity and Related Issues, El Paso VA Health Care System, El Paso, Texas

12/2/2014 | 14-05128-51 | [Summary](#) | [Report](#)

Veterans Integrated Service Network Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 1, 2017

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

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

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

Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and recommendations in the report of the CAP Review of the El Paso VA Health Care System, El Paso, Texas.


Jeffrey Milligan

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 1, 2017

From: Director, El Paso VA Health Care System (756/00)

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

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

1. I have reviewed and concur with the findings and recommendations in the report of the CAP Review of the El Paso VA Health Care System, El Paso, Texas.
2. Corrective action plans have been established, with some being already implemented and target dates have been set for the remaining items as detailed in the attached report.



Michael L. Amaral

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 facility clinical managers review Ongoing Professional Practice Evaluation data quarterly and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: The facility has expanded its "Best Practice" Ongoing Professional Practice Evaluation (OPPE) database and implemented a Human Resources service like process for completion and submission of OPPE documents. Service Chiefs now print or electronically prepare an OPPE form for each provider under their supervision from the OPPE database. The results are communicated to the provider on a semi-annual basis per CPM 11-123 and the document is signed (wet or digitally) by both the Service Chief and the provider. The signed form is placed in the provider's competency file and a copy is provided to the Credentialing and Privileging Office. The remitted/signed documents are stored in a secured electronic file in the "Credentialing" folder on the department's "Service Drive." This process was approved by the Professional Standards Board (PSB) on 5/17/2017 and is reflected in the Board's minutes. The facility will monitor compliance during the next scheduled review of FY17 to ensure completion.

Recommendation 2. We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOt database and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: The OIG Liaison at NCPS was consulted for guidance on how to deal with incidents that are entered in the Electronic Patient Event Report (ePER) database, but are not true patient incidents (i.e. disruptive behavior or supervisory related employee issues). All incidents in the ePER database will continue to be screened by the Patient Safety Manager to identify events which do not meet the criteria of an ePER (i.e. disruptive behavior or supervisory related employee issues). These non-ePERs will not be entered in WEBSPOt. On a monthly basis, a manual review will be conducted to ensure that all actual e-PERs have been entered into WEBSPOt and any numerical differences are identified. This data will be reported in the Patient Safety Committee and documented in the annual Patient Safety Report. The QSV committee, which

oversees the Patient Safety Committee will be utilized as a mechanism for ongoing monitoring via the QSV Dashboard. The Dashboard will be the primary document for comparison reporting of actual e-PERS being entered into WEBSPOt. It should be noted that these databases do not yield identical numbers even after you factor in the non-ePERS. The disruptive behavior incidents which get erroneously reported as an ePER, will be transferred to the Disruptive Behavior Reporting System (DBRS) and all other non-Patient Safety Events will be routed to the appropriate supervisor for action, and then closed by the Patient Safety Manager.

Recommendation 3. We recommended that the facility consistently take actions when data analyses indicated problems or opportunities for improvement and evaluate them for effectiveness in root cause analyses and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: In April 2017, the Patient Safety Manager instituted a Patient Safety Committee (PSC) to assist in monitoring Root Cause Analysis (RCA) actions approved by the Executive Leadership Team (ELT). Concurrently, the PSM will communicate with service managers regarding RCA actions requiring implementation in their departments. Random inspections/tracers will be conducted. The findings will be reported to the PSC and documented in the minutes, which will be reported and tracked by the QSV Board. Outcomes will be reported in the annual Patient Safety Report and documented in WEBSPOt upon completion.

Recommendation 4. We recommended that the facility revise the policy for anticoagulation management to include an anticoagulation quality assurance program.

Concur

Target date for completion: September 30, 2017

Facility response: The facility currently performs quality assurance monitoring for anticoagulation therapy. The data is reported to the Pharmacy & Therapeutics (P&T) Committee. CPM 119-25 (Anticoagulation Clinic) was updated to outline this process, which states the Anticoagulation Clinical Pharmacy Specialist (CPS) is responsible for ongoing monitoring and reporting to the P&T Committee. The draft CPM will be reviewed, and routed for approval prior to implementation.

Recommendation 5. We recommended that the facility develop and implement processes to address noncompliance with the treatment plan.

Concur

Target date for completion: September 30, 2017

Facility response: CPM 119-25 (Anticoagulation Clinic) was updated to outline the process to address treatment plan non-compliance. The updates reflected in the policy require the CPS to monitor non-compliant or suspected non-compliant patients closer, and provide them with continuous education. The draft CPM will be reviewed, and routed for approval prior to implementation.

Recommendation 6. We recommended that the facility define ways to minimize the risk of incorrect tablet strength dosing errors.

Concur

Target date for completion: September 30, 2017

Facility response: CPM 119-25 (Anticoagulation Clinic) was updated to reflect only one active warfarin prescription being in the individual medication profile. The policy also outlines that there will be limited use of multiple strengths of anticoagulant medication, and this practice will only be utilized during special circumstances related to the continuity of care. The draft CPM will be reviewed, and routed for approval prior to implementation.

Recommendation 7. We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: The facility does not have any inpatients. A CPRS Anticoagulation Consult template was created in Feb 2017 and is currently active and embedded within the consult. The template documents evidence of education to newly prescribed patients for anticoagulant medications. The template is currently being modified to make it a mandatory field. All Anticoagulation Consults are reported to the P&T Committee and the CPS will report education template usage compared to the number of newly prescribed anticoagulation medication patients.

Recommendation 8. We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.

Concur

Target date for completion: September 30, 2017

Facility response: This CNH Medical Director position is reflected in the current CNH Oversight Committee charter dated 2013. The charter is being revised to reflect position titles only, and also include the current facility Director's signature block. The next quarterly meeting is scheduled for May 30, 2017. Member attendance will be

documented on the roster. Any action items that involve the CNH Medical Director will be documented in the minutes. Attendance of the CNH Medical Director will be monitored for ongoing compliance throughout the remainder of the fiscal year.

Recommendation 9. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Concur

Target date for completion: September 30, 2017

Facility response: All new employees have Prevention and Management of Disruptive Behavior (PMDB) level I added to their required TMS training record with a 90 day from hire due date set in TMS. Additionally, PMDB levels II and III face to face training, will also be assigned via TMS as mandatory courses with an assigned completion date of 90 days from hire based on the WBRA. All supervisors have the ability to monitor the progress of their employees to prevent delinquencies in training requirements. The PMDB Coordinator will audit training records of all new employees every 30 days utilizing a spreadsheet, and report to the Disruptive Behavior Committee (DBC). This data will also be included in the committee minutes. Supervisors will be notified about any employee approaching their due date to facilitate timely completion. The annual data will be reported to the National PMDB Director.

The Disruptive Behavior Reporting System (DBRS) TMS training will be assigned to all staff currently employed at the facility, and also to new employees upon hire. New employees will be required to complete within 90 days from hire. The DBC Coordinator will audit training records every 30 days for new and existing employees, utilizing a spreadsheet. The facility training status will be reported to the DBC and included in the committee minutes. Supervisors will be notified about any employee approaching their due date, to facilitate timely completion. The annual data will be reported to the National PMDB Director.

Recommendation 10. We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens.

Concur

Target date for completion: September 30, 2017

Facility response: There will be continued monitoring of the daily post-traumatic stress disorder reminder. Applicable Nursing and provider personnel will be re-educated on the clinical reminder process, to include who is considered an acceptable provider for the purpose of performing suicide assessments for patients with positive PTSD screens. Additionally, Same Day Access for Mental Health was implemented on 12/31/2016. This implementation included a consult revision, requiring a mandatory suicide risk

assessment to be embedded within the consult. Two different note templates will be implemented. The Same Day new patient assessment template was drafted on 4/28/2017 and the expected completion of the established template is 8/1/2017. Monthly record reviews will be performed to monitor compliance and managed by the Mental Health Leadership Team.

OIG Contact and Staff Acknowledgments

| | |
|---------------------------|--|
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Endnotes

^a The references used for QSV 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 EOC included:

- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 7704(1), *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; February 16, 2016.
- Various requirements of The Joint Commission, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, Health Insurance Portability and Accountability Act, National Fire Protection Association.

^c The references used for Medication Management: Anticoagulation Therapy included:

- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

^d The references used for Diagnostic Care: POCT included:

- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
- The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.
- Boaz M, Landau Z, Wainstein J. Analysis of Institutional Blood Glucose Surveillance. *Journal of Diabetes Science and Technology*. 2010;4(6):1,514–15. Accessed July 18, 2016.

^e The references used for CNH Oversight included:

- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration’s Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

^f The references used for Management of Disruptive/Violent Behavior included:

- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Public Law 112-154. Honoring America’s Veterans and Caring for Camp Lejeune Families Act of 2012. August 6, 2012. 126 Stat. 1165. Sec. 106.
- Acting Deputy Under Secretary for Health for Operations and Management. “Meeting New Mandatory Safety Training Requirements using Veterans Health Administration’s Prevention and Management of Disruptive Behavior (PMDB) Curriculum.” memorandum. November 7, 2013.

^g The references used for PTSD Care included:

- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
- VA Memorandum, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 2015.
- *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, Version 2.0, October 2010.
- *VHA Technical Manual – PTSD*, VA Measurement Manual PTSD-51.

^h The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.

ⁱ The reference used for Patient Aligned Care Team Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: December 19, 2016.