DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Central Texas Veterans Health Care System

Temple, Texas

CHIP REPORT | REPORT #18-01137-15 | NOVEMBER 29, 2018

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Figure 1. *Central Texas Veterans Health Care System, Temple, Texas (Source: https://vaww.va.gov/directory/guide/, accessed on September 26, 2018)*

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Central Texas Veterans Health Care System (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the overall efforts of the Office of Inspector General (OIG) to ensure that our nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health;
7. Long-term Care;
8. Women's Health; and
9. High-risk Processes.

This review was conducted during an unannounced visit made during the week of May 21, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, Assistant Director–Austin, and Assistant

Director–Waco. Organizational communication and accountability are carried out through a committee reporting structure, with the Quality, Safety and Value Executive Board having oversight for various councils, such as the Administrative Executive, Environment of Care Executive, Patient Care Services Executive, and Clinical Executive Councils. The leaders are members of the Quality, Safety and Value Executive Board through which they track, trend, and monitor quality of care and patient outcomes.

The Director and Associate Director were assigned to their positions in February 2017 and March 2017, respectively; and the Chief of Staff and the ADPCS had been in their positions since 2014. The Assistant Director–Waco was assigned in August 2016. Apart from the Assistant Director–Austin appointed in March 2018, the executive leaders had been working together as a team since March 2017. However, at the time of the OIG inspection, the ADPCS had accepted a position outside of the VA, and the Facility was actively recruiting for this position.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted the results for executive leaders were generally higher than those of the Facility and Veterans Health Administration (VHA). Facility leaders appeared actively engaged with employees, and the leaders verbalized ongoing efforts to improve the culture of the organization.

In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that the Facility's inpatient survey scores were above the VHA average, while opportunities appear to exist to improve patient experiences in outpatient settings. Facility leaders reported implementing processes and plans to improve patient experiences.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[1] Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current "3-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and Patient Safety Indicator data and identified the presence of

[1] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" rating system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

[2] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

The OIG noted findings in five of the eight areas reviewed and issued 18 recommendations that are attributable to the Director, Chief of Staff, ADPCS, Associate Director, Assistant Director–Austin, and Assistant Director–Waco. These are briefly described below.

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations processes.

Environment of Care

The OIG found privacy measures were in place. However, the OIG noted Facility-wide deficiencies with the accessibility of personal protective equipment and with delays in patients receiving prescribed sleep apnea equipment. The OIG also identified deficiencies with environmental cleanliness at the parent Facility; panic alarm testing at the representative community based outpatient clinic and the Waco campus locked inpatient mental health unit; and the annual review of the emergency management program at the parent Facility.

Medication Management

The OIG found general compliance with requirements in pharmacy operations, including annual physical security surveys and requirements for Controlled Substances (CS) Coordinators. However, the OIG identified deficiencies with CS Coordinator reports, requirements for CS Inspectors, CS area inspections, and pharmacy inspections.

Women's Health

The OIG found general compliance with many of the performance indicators reviewed, including electronically linking mammogram results to the order, scanning hard copy reports, and communicating results and any recommended course of action to the ordering provider. However, the OIG identified a deficiency with providers communicating results to patients.

High-risk Processes

The OIG found compliance with requirements related to Facility policy, performance of an annual risk assessment, routine discussions of central line-associated bloodstream infection data, provision of education materials, and the use of a checklist for central line insertion and maintenance. However, the OIG identified a deficiency with staff education.

Summary

In the review of key care processes, the OIG issued 18 recommendations that are attributable to the Director, Chief of Staff, ADPCS, Associate Director, Assistant Director–Austin, and Assistant Director–Waco. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 68-69, and the responses within the body of the report for the full text of the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
for Healthcare Inspections

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Central Texas Veterans Health Care System (Facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[3,4] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[5] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Posttraumatic Stress Disorder (PTSD) Care; Long-term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-risk Processes: Central Line-associated Bloodstream Infections (CLABSI) (see Figure 2).[6]

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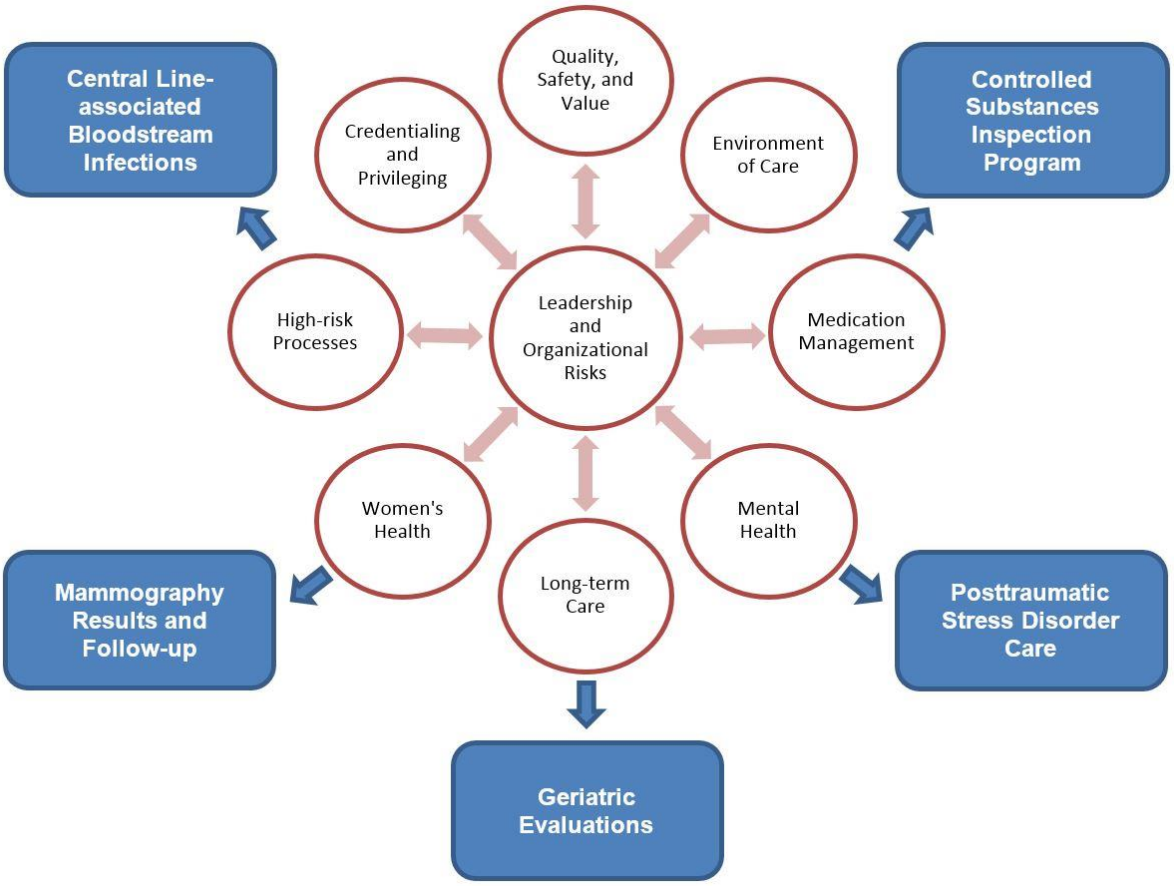
[3] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[4] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (Website accessed on March 1, 2018.)

[5] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (Website accessed on March 1, 2018.)

[6] CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

Figure 2. FY 2018 Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services



Source: VA OIG

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[7] and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for April 13, 2015,[8] through May 21, 2018, the date when an unannounced week-long site visit commenced.

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

While on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

[7] The OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect Facility accreditation status.

[8] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all the selected clinical areas of focus.[9] To assess the Facility's risks, the OIG considered the following organizational elements:

1. Executive leadership stability and engagement,
2. Employee satisfaction and patient experience,
3. Accreditation/for-cause surveys and oversight inspections,
4. Indicators for possible lapses in care, and
5. VHA performance data.

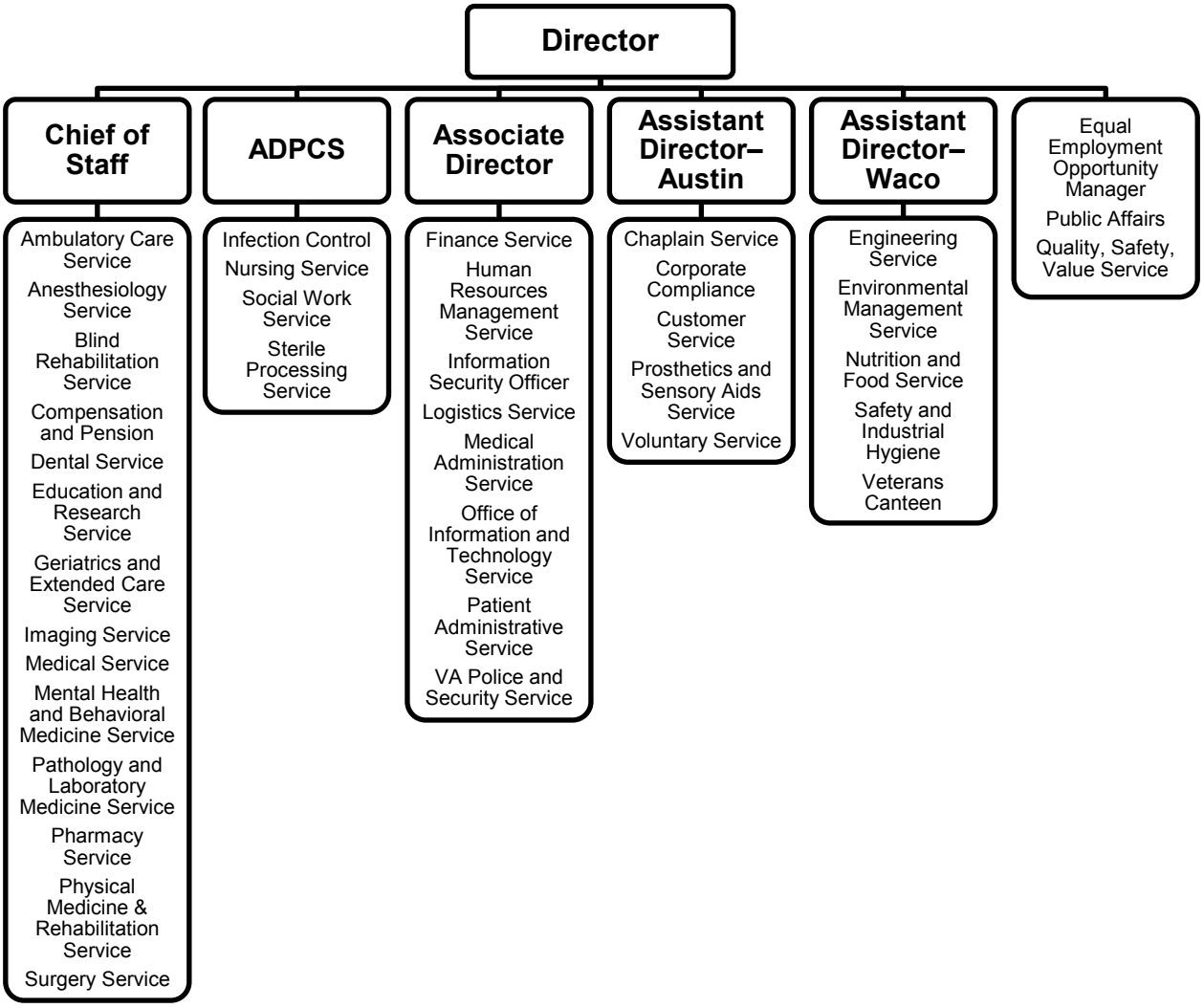
Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, Assistant Director–Austin, and Assistant Director–Waco. The Chief of Staff and ADPCS are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

The Facility's executive leadership team appeared relatively stable. The Director and Associate Director were assigned to their positions in February 2017 and March 2017, respectively; and the Chief of Staff and ADPCS had been in their positions since 2014. The Assistant Director–Waco was assigned in August 2016. Apart from the Assistant Director–Austin, appointed in March 2018, the executive leaders had been working together since March 2017. However, at the time of the OIG inspection, the ADPCS had accepted a position outside of the VA, and the Facility was actively recruiting for this position.

[9] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx. (Website accessed on February 2, 2017.)

Figure 3. Facility Organizational Chart



Source: Central Texas VA Health Care System (received May 22, 2018)

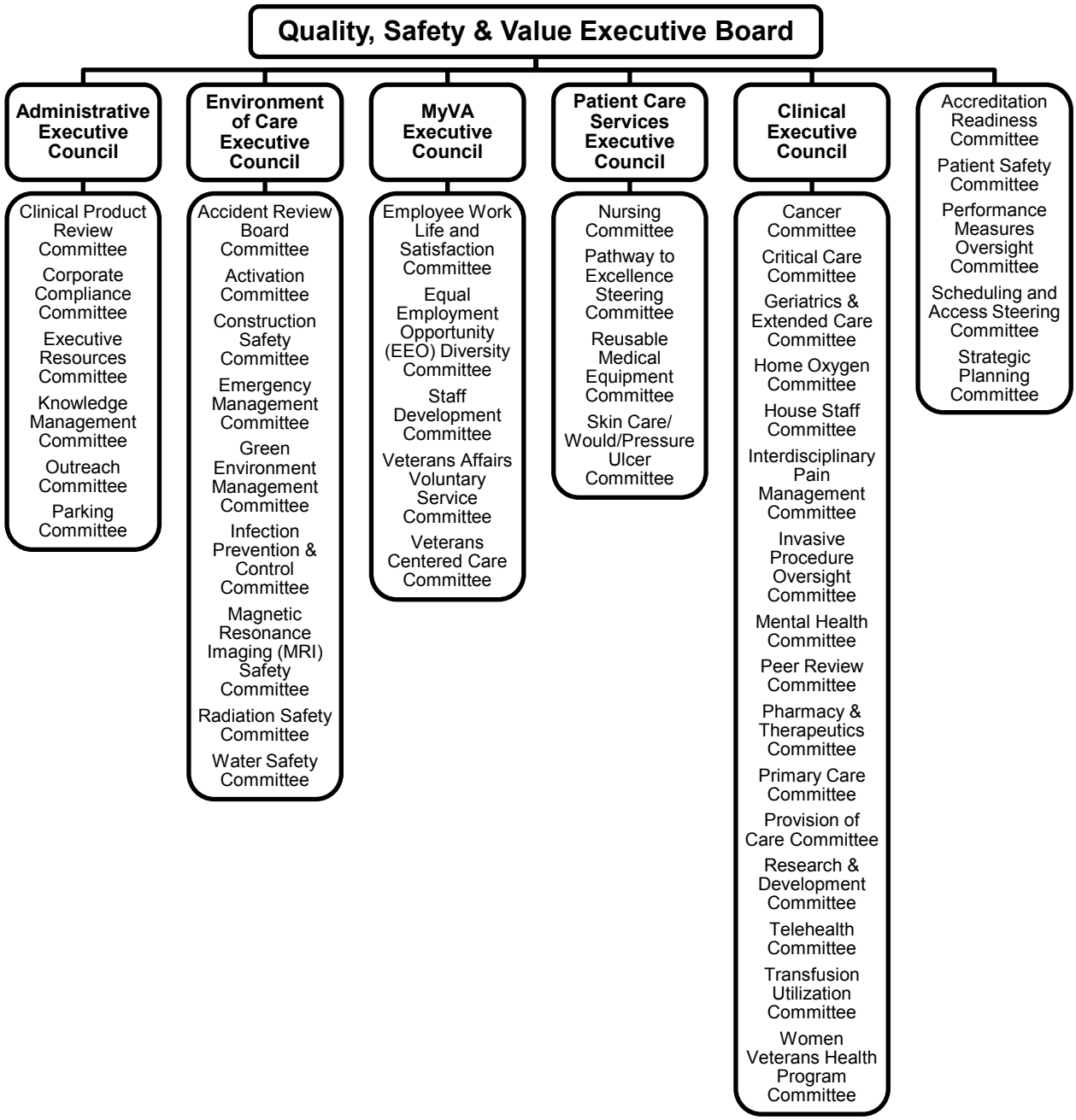
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members spoke knowledgeably about actions taken during the previous 12 months to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Quality, Safety and Value Executive Board, which tracks, trends, and

monitors quality of care and patient outcomes. The Director serves as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Quality, Safety and Value Executive Board also oversees various councils, such as the Administrative Executive, Environment of Care Executive, Patient Care Services Executive, and Clinical Executive Councils. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Central Texas VA Health Care System (received May 22, 2018)

Employee Satisfaction and Patient Experience

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

To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction survey results and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1–3 provide relevant survey results for VHA, the Facility, and selected Facility executive leaders.[10]

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[11] The Facility average for both selected survey questions was similar to or below the VHA average. However, the leaders' results for both survey questions were generally higher than the Facility and VHA averages.[12] In all, employees appear generally satisfied with Facility leaders.

[10] Rating is based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, Associate Director, and Assistant Directors.

[11] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

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

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director –Austin Average	Asst. Director –Waco Average
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	65.8	73.2	71.6	76.2	85.6	79.8	65.1
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied) –5 (Very Satisfied)	3.3	3.4	4.1	4.0	3.4	4.2	4.1	3.5

Source: VA All Employee Survey (accessed April 20, 2018)

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The Facility averages for the selected survey questions were similar to the VHA average; however, results for the leaders were generally higher than the Facility and VHA averages. Overall, leaders appear to provide a safe workplace environment where employees feel comfortable bringing forth issues or ethical concerns, and the leaders verbalized ongoing efforts to improve the culture of the organization.

Table 2. Survey Results on Employee Attitudes toward Workplace (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director (Austin) Average	Asst. Director (Waco) Average
All Employee Survey Q43. *My supervisor encourages people to speak up when they disagree with a decision.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.7	3.9	4.0	4.2	4.1	4.0	3.6
All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.0	3.9	4.0	4.4	3.9	3.8
All Employee Survey Q75. *I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.8	3.8	4.1	4.1	4.4	4.0	3.8

Source: VA All Employee Survey (accessed April 20, 2018)

VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders (see Table 3). For this Facility, the inpatient survey results were above the VHA average, while opportunities appear to exist to improve patient experiences in

outpatient settings. Facility leaders reported implementing processes and plans to improve patient experiences.

Table 3. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.7	70.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.4	83.9
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	69.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.2	72.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 22, 2017)

Accreditation/For-Cause Surveys[13] and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders

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

respond to identified problems. Table 4 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC).[14]

The Facility has closed all but two of the recommendations for improvement as listed in Table 4.[15] One OIG recommendation regarding adequate staffing to ensure timely physical medicine and rehabilitation consultations and appointments and one JC recommendation of installing doors with latching hardware on the intensive care unit remained open at the time of the OIG visit. Leaders were actively addressing both open recommendations.

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[16] and College of American Pathologists,[17] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted inspections of the Facility's Community Living Center.[18]

[14] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VA medical facilities for over 35 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

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

[16] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

[17] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

[18] Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

Table 4. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas, July 15, 2015*)	April 2015	10	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Central Texas Veterans Health Care System, Temple, Texas, July 27, 2015*)	April 2015	7	0
OIG (*Healthcare Inspection–Physical Medicine and Rehabilitation Services Consult Process Concerns, Central Texas Veterans Health Care System, Temple, Texas, September 5, 2017*)	May 2016	3	1
TJC	October 2017		
• Hospital Accreditation		48	1
• Behavioral Health Care Accreditation		4	0
• Home Care Accreditation		3	0

Sources: OIG and TJC (Inspection/survey results verified with the Chief of Quality on May 24, 2018)

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 summarizes key indicators of risk since the OIG's previous April 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of May 21, 2018.[19]

[19] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the Central Texas VA Health Care System is a high-complexity (1a) affiliated Facility as described in Appendix B.)

Table 5. Summary of Selected Organizational Risk Factors (April 2015 to May 21, 2018)

Factor	Number of Occurrences
Sentinel Events[20]	10
Institutional Disclosures[21]	6
Large-Scale Disclosures[22]	0

Source: Central Texas VA Health Care System's Patient Safety Manager (received May 22, 2018)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[23] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

[20] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[21] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.

[22] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

[23] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (Website accessed on March 8, 2017.)

Table 6. Patient Safety Indicator Data
(October 1, 2015, through September 30, 2017)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 17	Facility
Pressure ulcers	0.60	0.12	0.00
Death among surgical inpatients with serious treatable conditions	100.97	102.04	100.00
Iatrogenic pneumothorax	0.19	0.11	0.19
Central venous catheter-related bloodstream infection	0.15	0.08	0.15
In-hospital fall with hip fracture	0.08	0.05	0.00
Perioperative hemorrhage or hematoma	1.94	1.16	0.00
Postoperative acute kidney injury requiring dialysis	0.88	0.72	0.76
Postoperative respiratory failure	5.55	3.12	1.89
Perioperative pulmonary embolism or deep vein thrombosis	3.29	3.89	3.46
Postoperative sepsis	4.00	3.93	4.61
Postoperative wound dehiscence	0.52	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.16	0.00

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

Three Patient Safety Indicator measures (iatrogenic pneumothorax, central venous catheter-related bloodstream infection, and postoperative acute kidney injury requiring dialysis) show a higher observed rate than the Veterans Integrated Service Network (VISN) 17. The numerator for these measures were two or less. Clinical managers reviewed these events and determined that no action was required.

Two Patient Safety Indicator measures (perioperative pulmonary embolism or deep vein thrombosis and postoperative sepsis) show a higher observed rate than the VHA. Seven patients developed perioperative pulmonary embolism or deep vein thrombosis. The Chief of Staff reported that the Facility's Critical Care Committee thoroughly reviewed each patient's record and did not identify any opportunity for improvement. Six patients developed postoperative sepsis. The Chief of Staff and ADPCS reported that the Critical Care Committee reviewed each case and determined that clinicians had not been aggressively managing patients with sepsis. Clinical managers reported updating sepsis protocols, hiring an infection preventionist, providing staff education, and closely monitoring improvements through the Performance Measures Oversight Committee.

Additionally, the OIG identified an organizational risk while conducting EOC rounds at the Austin CBOC. The OIG learned of a significant delay in patients receiving prosthetic supplies, specifically sleep apnea equipment. Although identified at the CBOC, the delay was found to be Facility wide. The Associate Director confirmed this issue and reported that a budgetary and ordering disagreement between Logistics and Prosthetics Services resulted in this delay. To resolve the issue, the Facility sought guidance from the VISN and VHA Central Office who clarified expectations and responsibilities for Prosthetics to order and purchase the equipment and Logistics to track and monitor supplies upon receipt. Due to the impact in patient care, this will be a recommendation under the EOC section of this report.

The above organizational risk factors may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and closely monitored.

Veterans Health Administration Performance Data

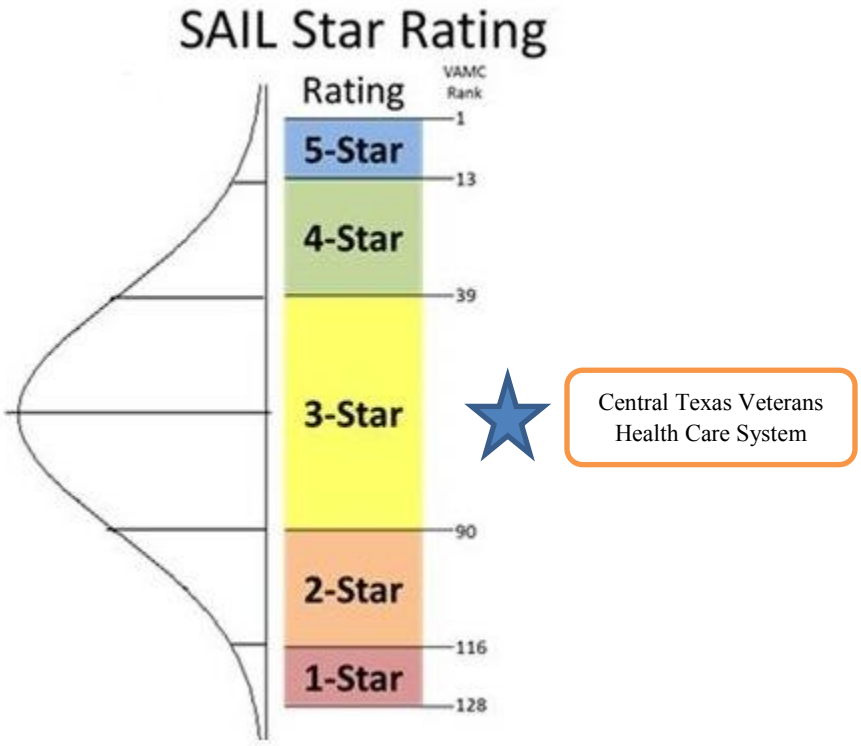
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[24]

VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[25] As of June 30, 2017, the Facility was rated at "3-Star" for overall quality. Updated data as of June 30, 2018, indicates that the Facility remains at "3-Star" for overall quality.

[24] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

[25] Based on normal distribution ranking quality domain of 128 VA Medical Centers.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)

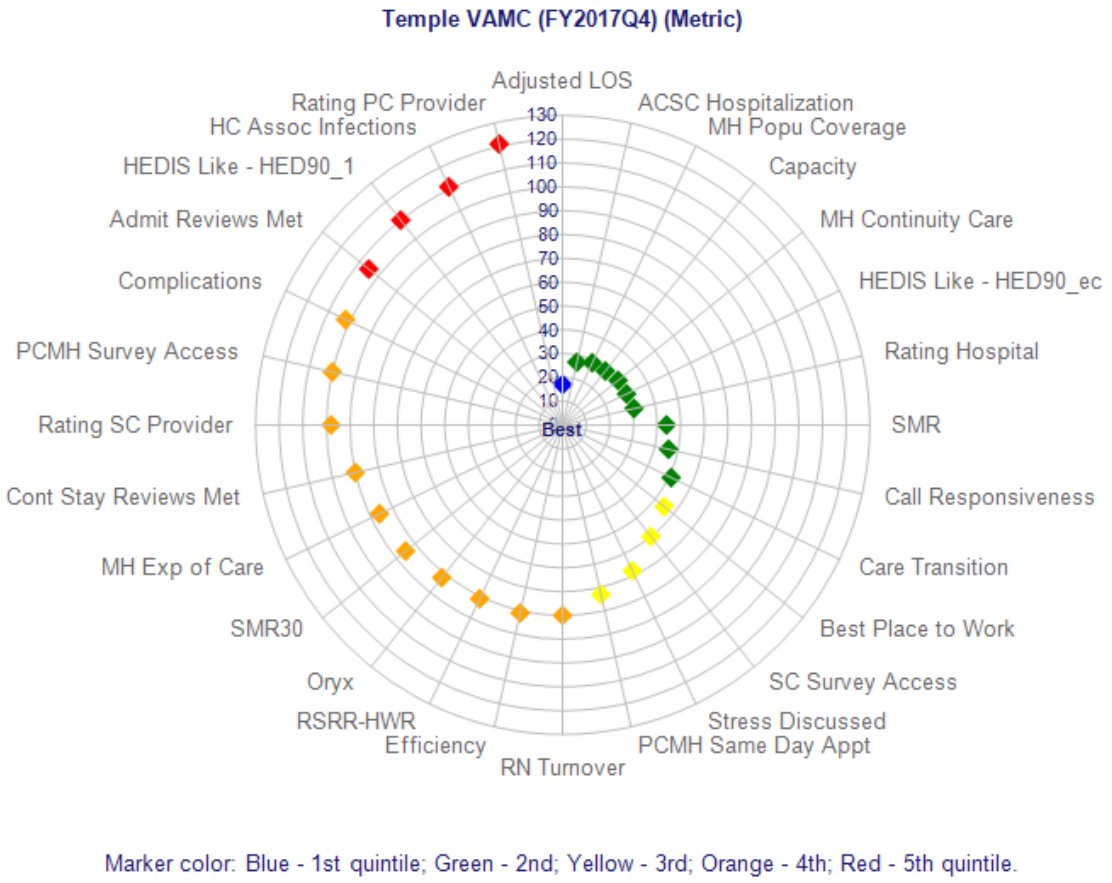


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed April 20, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Adjusted Length of Stay (LOS), Capacity, Rating (of) Hospital, and Care Transition).[26] Metrics that need improvement are denoted in orange and red (for example, Registered Nurse (RN) Turnover, Mental Health (MH) Experience (Exp) of Care, Complications, and Rating (of) Primary Care (PC) Provider).

[26] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2017)



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

Conclusion

The Facility's executive leadership team appeared relatively stable, with four of the five positions permanently filled for over one year prior to the OIG's on-site visit. Selected survey scores related to employee satisfaction and trust in the Facility's executive leaders were generally higher than VHA averages. In review of patient experience survey data, inpatient satisfaction scores were above VHA averages, while opportunities appeared to exist to improve outpatient experiences. Facility leaders were actively engaged with employees and patients and were actively working to sustain and further improve employee and patient engagement and satisfaction. Organizational leaders appeared to support efforts related to patient safety, quality care, and other positive outcomes (such as implementing processes to improve quality care and

initiating plans to maintain positive perceptions of the Facility through active stakeholder engagement). However, the presence of organizational risk factors, as evidenced by Patient Safety Indicator data and delays in patients receiving sleep apnea equipment, may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. Although the leadership team was knowledgeable about selected SAIL metrics, they should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the "3-Star" rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[27] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[28]

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,[29] utilization management (UM) reviews,[30] and patient safety incident reporting with related root cause analyses (RCAs).[31]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[32]

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[27] VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

[28] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

[29] According to VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010, this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. (Due for recertification June 30, 2015, but has not been updated.)

[30] According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[31] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

[32] VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[33]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into VHA's patient safety reporting system[34]
  - Annual completion of a minimum of eight RCAs[35]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

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

[33] For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

[34] WebSPOT has been the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database. However, it is expected that by April 1, 2018, all facilities will have implemented the new Joint Patient Safety Reporting System (JPSR); and it is anticipated that all previous patient safety event reporting systems will be discontinued by July 1, 2018.

[35] According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs, with the balance being aggregated reviews or additional individual RCAs.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[36]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[37]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[38]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months prior to the on-site visit,[39] and 20 LIPs who were re-privileged within 12 months prior to the visit.[40] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Requested privileges

[36] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] The 18-month period was from November 22, 2016, through May 22, 2018.

[40] The 12-month review period was from May 22, 2017, through May 22, 2018.

        - Facility-specific
        - Service-specific
        - Provider-specific
    - Service chief recommendation of approval for requested privileges
    - Medical Staff Executive Committee decision to recommend requested privileges
    - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
    - Evaluation initiated
        - Timeframe clearly documented
        - Criteria developed
        - Evaluation by another provider with similar training and privileges
        - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
    - Determination to continue privileges
        - Criteria specific to the service or section
        - Evaluation by another provider with similar training and privileges
        - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in the FPPE and OPPE processes.

Focused Professional Practice Evaluation

VHA requires that all LIPs new to the facility have time-limited FPPEs completed and documented in the practitioner's provider profile and reported to an appropriate committee of the Medical Staff.[41] The process involves the evaluation of privilege-specific competence of the practitioner who has not had documented evidence of competently performing the requested

[41] VHA Handbook 1109.19.

privileges. FPPE results must be reported to the Medical Staff Executive Council to allow a thorough review of the practitioner's practice prior to making the determination to continue privileges.[42]

For 5 of the 10 FPPE profiles reviewed, the OIG found that supporting documentation did not include clearly defined timeframes. This may have resulted in an inefficient process for evaluating these LIPs. Facility managers believed documenting a general date range met the timeframe requirement.

Additionally, for five of nine applicable LIPs, the OIG found no evidence that the completed FPPEs were presented to the Facility's Medical Staff Executive Council for consideration and recommendation to continue initially granted privileges. This resulted in LIPs continuing to provide care without a complete review of their practice. Service Chiefs were aware FPPE results must be reported to the Medical Staff Executive Council and cited that a lack of oversight contributed to this deficiency.

Recommendation 1

1. The Chief of Staff ensures Service Chiefs include clearly delineated timeframes in practitioners' Focused Professional Practice Evaluation competency reviews and monitors compliance.

Facility concurred.

Target date for completion: April 2019

Facility response: All Service Focused Professional Practice Evaluations (FPPE's) have been modified to include clearly delineated timeframes. The delineated timeframe for each FPPE is no more than 90 days in duration. This will be monitored by the Medical Staff Executive Council (MSEC) until 90 percent, or greater, compliance is demonstrated for a minimum of six consecutive months or two quarters.

Recommendation 2

2. The Chief of Staff ensures Service Chiefs present the results of completed Focused Professional Practice Evaluations to the Medical Staff Executive Council to recommend continuing the initially granted privileges and monitors compliance.

[42] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: April 2019

Facility response: All Service FPPE's are now presented to MSEC at the completion of 90 days for review. If all criteria meet target, the MSEC recommends continuing the initially granted privileges with continuing monitoring of compliance on an OPPE. This will be monitored by the Medical Staff Executive Council (MSEC) until 90 percent, or greater, compliance is demonstrated for a minimum of six consecutive months or two quarters.

Ongoing Professional Practice Evaluation

VHA requires that at the time of re-privileging, Service Chiefs consider relevant service- and practitioner-specific evaluation data utilizing defined criteria when recommending the continuation of LIPs' privileges to the Executive Committee of the Medical Staff.[43] This data is maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. The OPPE process is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact the quality of care and patient safety.[44]

For 7 of 20 provider profiles used to support the renewal of practitioners' privileges, the OIG found no evidence that service-specific criteria were utilized to assess competency. Additionally, for the two applicable pathology specialty providers, the OIG found no evidence of the use of minimum-required specialty criteria for competency evaluation. As a result, providers continued to deliver care without a thorough evaluation of their practice. Credentialing and privileging staff reported Service Chiefs had been educated about service- and specialty-specific criteria; however, a lack of Service Chief oversight led to this noncompliance.

Recommendation 3

3. The Chief of Staff ensures Service Chiefs include service-specific data in Ongoing Professional Practice Evaluations and monitors compliance.

[43] VHA Handbook 1100.19.
[44] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: April 2019

Facility response: Revised OPPE/FPPE templates to include Service Specific; Section Specific, and/or Provider Specific criteria in the Clinical Quality/Knowledge/Judgement Section and limited service-related modifications have been developed and adopted by the Medical Staff Executive Council. The Templates in GI, Nuclear Medicine and Pathology and Laboratory Medicine Service have been specifically modified to include specific criteria as directed in the Memorandum from the DUSHOM dated August 29, 2017, "Requirements for Peer Review of Solo Practitioners." The MSEC will monitor 100 percent of Service OPPE/FPPE's to ensure compliance with required Service Specific; Section Specific, and/or Provider Specific criteria in the Clinical Quality/Knowledge/Judgement Section of the OPPE/FPPE templates to ensure 90 percent, or greater, compliance for a minimum of six months or two quarters.

Recommendation 4

4. The Chief of Staff ensures that the Chief, Pathology and Laboratory Medicine Service, includes the required pathology-specific criteria, as applicable, in pathology practitioners' Ongoing Professional Practice Evaluations and monitors compliance.

Facility concurred.

Target date for completion: April 2019

Facility response: The Pathology and Laboratory Medicine OPPE/FPPE template has been modified to include the required pathology-specific criteria. MSEC will monitor 100% of the Pathology and Laboratory Medicine templates to ensure 90 percent, or greater, for a minimum or six months or two quarters.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[45]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients in the locked MH Unit and with Emergency Management processes.[46]

VHA requires managers to ensure capacity for MH services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty. Inpatient MH settings must also provide a healing, recovery-oriented environment.[47]

VHA requires managers to establish a comprehensive Emergency Management program to ensure continuity of patient care and hospital operations in the event of a disaster or emergency, which includes conducting a Hazard Vulnerability Analysis (HVA) and developing an Emergency Operations Plan (EOP).[48] These requirements allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services provided by facilities. VHA also requires managers to develop Utility Management Plans to ensure reliability and reduce failures of electrical power distribution systems in accordance with TJC,[49] Occupational Safety and Health Administration,[50] and

[45] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

[46] Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[47] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

[48] VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

[49] TJC. EOC standard EC.02.05.07.

[50] Occupational Safety and Health (OSHA) is part of the US Department of Labor. OSHA assures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance.

National Fire Protection Association standards.[51] The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG team inspected 17 patient care areas at the Temple and Waco campuses. At the Temple campus, the OIG inspected six inpatient units (intensive care, 3K–medical/surgical, 4K–medical, post anesthesia care, and Community Living Center Chism Trail and Hero's Haven/Warrior's Way), the Emergency Department, and four outpatient clinics (primary care, MH, infectious disease, and women's health). At the Waco campus, the OIG inspected three inpatient units (residential MH, Community Living Center, and locked MH) and three outpatient clinics (combined specialty care, MH, and primary care). The team also inspected the Austin CBOC. The OIG reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Locked MH Unit

[51] National Fire Protection Association (NFPA) is a global nonprofit organization devoted to eliminating death, injury, and property and economic loss due to fire, electrical, and related hazards.

  - Bi-annual MH EOC Rounds
  - Nursing station security
  - Public area and general unit safety
  - Patient room safety
  - Infection prevention
  - Availability of medical equipment and supplies
- Emergency Management
  - Hazard Vulnerability Analysis (HVA)
  - Emergency Operations Plan (EOP)
  - Emergency power testing and availability

Conclusion

Privacy measures were in place at the Temple and Waco campuses and at the Austin CBOC. The OIG noted Facility-wide deficiencies with the accessibility of personal protective equipment (PPE) and with delays in patients receiving prescribed sleep apnea equipment. The OIG also found deficiencies with environmental cleanliness at the Temple campus, general safety at the Austin CBOC and in the inpatient MH unit at the Waco campus, and the Facility's Emergency Management program that warranted recommendations for improvement.

Infection Prevention: Personal Protective Equipment

Occupational Safety and Health Administration requires employers to ensure appropriate PPE is readily accessible at the worksite.[52] Use of PPE reduces the risk of exposure to, and possible infection from, bloodborne pathogens and other potentially infectious materials.[53] In 6 of 17 applicable patient care areas inspected, masks and gowns were locked in clean supply rooms and not readily accessible to staff.[54] The lack of accessible PPE places staff at an increased risk for infection. Clinic managers thought the Facility's PPE storage practice met requirements.

[52] OSHA, 29 CFR 191.1030.

[53] OSHA Fact Sheet, *Personal Protective Equipment (PPE) Reduces Exposure to Bloodborne Pathogens*. https://www.osha.gov/OshDoc/data_BloodborneFacts/bbfact03.pdf. (Website accessed on August 9, 2018.)

[54] Temple campus post anesthesia care unit, primary care clinic, infectious disease clinic, and women's health clinic; Waco campus MH clinic; and the Austin CBOC.

Recommendation 5

5. The Associate Director ensures personal protective equipment is readily accessible and monitors compliance.

Facility concurred.

Target date for completion: April 2019

Facility response: The facility is conducting a standardized risk assessment throughout CTVHCS in all clinical areas to identify the high-risk areas and appropriate placement and accessibility of personal protective equipment (PPE). Results of the assessments will be reviewed by representatives from Nursing, Infection Prevention and Safety to identify specific actions to correct any issues identified impacting appropriate placement and levels of PPE, and the ease of access to the PPE. Implementation of corrective actions will be tracked by the Environment of Care Executive Council (EOCEC) to completion. The facility will update the PPE assessment annually with oversight direction by the EOCEC.

Environmental Cleanliness: Equipment Storage Rooms

TJC requires hospitals to maintain and continually monitor the environment of care and remediate conditions to ensure safe patient care.[55] At the Temple campus, the OIG noted dirty equipment storage room floors in four patient care areas.[56] Dirty storage rooms may expose stored equipment to harmful or infectious agents which could be transferred to patients during the process of care. Facility staff reported these equipment rooms had not been under the purview of the Environmental Management Service (EMS); however, when identified during OIG's inspections, the EMS Chief stated these equipment storage rooms would be incorporated into the Facility's routine cleaning schedule.

Recommendation 6

6. The Assistant Director–Waco ensures that a clean environment is maintained throughout the Facility and monitors compliance.

Facility concurred.

Target date for completion: April 2019

Facility response The Chief of Environmental Management Service (EMS) has identified all the areas where there is an equipment room and has obtained access to these rooms. EMS Housekeeping staff will check these rooms weekly and clean as needed. The using service will

[55] TJC. Environment of Care standard EC.02.06.01, EP20, July 2017.

[56] Dirty equipment rooms were noted during EOC inspections of the Temple campus primary care clinic and 4K–Medical and Community Living Center Chism Trail and Hero's Haven/Warrior's Way units.

also monitor these rooms and notify the Housekeeping Section if a room needs serviced. The Environment of Care Specialist, EMS will monitor this for a minimum of six consecutive months with the goal of 90 percent compliance. Monitoring will be ongoing and reported to the Environment of Care Executive Council.

Availability of Medical Equipment and Supplies: Sleep Apnea Equipment

VHA requires prescribed prosthetic equipment, sensory aids, and devices be furnished in a timely manner to veterans.[57] During the OIG's on-site visit at the Austin CBOC, staff reported Facility-wide delays in patients receiving prescribed sleep apnea equipment. The Associate Director was aware of the delays and cited that a disagreement between Logistics and Prosthetics Services, regarding responsibility for ordering and purchasing sleep apnea equipment, as the reason for noncompliance. The Associate Director stated that, to resolve the matter, the Facility received clarification from VISN 17 and VHA Central Office that Prosthetics Service orders and purchases equipment, and Logistics tracks and monitors supplies upon receipt.

Recommendation 7

7. The Associate Director and Assistant Director–Austin ensure that prescribed sleep apnea equipment is furnished timely to patients and monitor compliance.

Facility concurred.

Target date for completion: May 2019

Facility response: Central Texas Veterans Health Care System made a significant change in managing inventory from the Prosthetics Inventory Package to the Generic Inventory Package (GIP). Prosthetics service implemented the use of the Generic Inventory Package (GIP) at all sites on October 1, 2018. The GIP was established to monitor and set par levels for prosthetic devices. Turn rates will continue to be monitored to determine if par levels need to be adjusted. The Chief, Prosthetics and Sensory Aids Service will submit results of the monthly audits to the Assistant Director – Austin until 95 percent compliance is demonstrated for six consecutive months.

[57] VHA Directive 1173, *Prosthetic and Sensory Aids Service*, June 27, 2008. (Due for recertification on or before May 2013 but has not been updated.)

Austin CBOC Panic Alarm Testing

VHA requires that Police and Security Operations test appropriate physical security precautions and equipment, including panic alarms in high-risk outpatient areas.[58] At the Austin CBOC, the OIG found evidence of monthly alarm system testing; however, no follow-up actions were taken to address identified deficiencies such as an incomplete or failed test. This resulted in a lack of assurance of a safe environment for patients and staff. Facility managers believed they were meeting requirements by conducting the tests and were unaware that follow up for system failures was required.

Recommendation 8

8. The Associate Director ensures VA Police and Security Service regularly test panic alarms and take follow-up actions for identified deficiencies at the Austin Community Based Outpatient Clinic and monitors compliance.

Facility concurred.

Target date for completion: May 2019

Facility response: The Chief of Police has now redesigned the testing process that the officers use monthly. The panic alarms are tested monthly and any failures of alarms are documented in the alarm book. All end users of the LYNX panic alarm system are required to test their issued alarm monthly. When officers run a monthly report and find incomplete test on the panic alarms, the officers are then given a computer-generated list of all alarms that they manually test and document in the testing book. The Police Service staff now have full control over the LYNX panic alarm system and when officers find alarms that are not working during the monthly testing police staff submit an Office of Information Technology (OIT) Help Desk ticket and make on the spot corrections to alarms that are found to be not working. All alarms in Austin are tested monthly and 100% of the failed alarms are repaired or corrected by the police service staff within the required thirty-day testing cycle. All alarm testing and any associated issues are tracked and reported to the Environment of Care Executive Council. Results of the monitoring will be reported monthly until 90 percent, or greater, compliance is achieved for six consecutive months.

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

Locked Mental Health Unit Panic Alarm Testing

VHA requires that Police and Security Operations test appropriate physical security precautions and equipment, including panic alarms in locked MH units.[59] At the Waco campus inpatient MH unit, the OIG found evidence of monthly alarm system testing; however, no follow-up actions were taken to address identified deficiencies such as incomplete or failed tests. This resulted in a lack of assurance of a safe environment for patients and staff. Facility staff believed they were meeting requirements by conducting the tests and were unaware that follow up for system failures was required.

Recommendation 9

9. The Associate Director ensures VA Police and Security Service regularly test panic alarms and take follow-up actions for identified deficiencies at the Waco campus locked mental health unit and monitors compliance.

Facility concurred.

Target date for completion: May 2019

Facility response: The Chief of Police has now redesigned the testing process that the officers use monthly. The panic alarms are tested monthly and any failures of alarms are documented in the alarm book. All end users of the LYNX panic alarm system are required to test their issued alarm monthly. When officers run a monthly report and find incomplete test on the panic alarms, the officers are then given a computer-generated list of all alarms that they manually test and document in the testing book. The Police Service staff now have full control over the LYNX panic alarm system and when officers find alarms that are not working during the monthly testing police staff submit an OIT ticket and make on the spot corrections to alarms that are found to be not working. All alarms in Waco are tested monthly and 100% of the failed alarms are repaired or corrected by the police service staff within the required thirty-day testing cycle. All alarm testing and any associated issues are tracked and reported to the Environment of Care Executive Council. Results of the monitoring will be reported monthly until 90 percent, or greater, compliance is achieved for six consecutive months.

Emergency Management

VHA requires that facilities perform an annual review of the Emergency Operations Plan (EOP). This review is required to be documented in writing, evaluated by the Emergency Management Committee, and approved by executive leadership.[60] The OIG found no evidence of an annual

[59] VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, December 8, 2016.

[60] VHA Directive 0320.01.

review of the EOP for 2017, resulting in the lack of assurance that information and priorities are updated and reflective of current risks to the Facility. Facility leaders were aware of the requirement and reported insufficient staffing, employee turnover, and hiring delays as reasons for noncompliance.

Recommendation 10

10. The Assistant Director–Waco ensures that the Emergency Operations Plan is reviewed annually by the Emergency Management Committee and approved by executive leadership and monitors compliance.

Facility concurred.

Target date for completion: January 2019

Facility response: The Emergency Manager, along with the Emergency Management Committee, will continue to review a part of the Emergency Operations Plan during each meeting. Once approved by the EMC, the Annual Review Memorandum will go through the Environment of Care Executive Council (EOCEC) for approval, and then the Quality Safety & Value Executive Board (QSVEB). The Annual review will be completed and submitted for approval by the Executive Leadership Team no later than January 31, 2019.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[61] Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.[62]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.[63] Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[64] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[65] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[66] CS inspection quarterly trend reports for the prior four quarters;[67] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
  - Monthly summary of findings to the Director
  - Quarterly trend report to the Director
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police

[61] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (Website accessed on August 21, 2017.)

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

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

[64] VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

[65] The review period was October 1, 2017, through March 31, 2018.

[66] The review period was May 1, 2017, through April 30, 2018.

[67] The four quarters were from April 1, 2017, through March 31, 2018.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[68]
  - Accountability for all prescription pads in pharmacy

[68] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

The OIG found general compliance with requirements in pharmacy operations, including annual physical security surveys and requirements for CSCs. However, the OIG identified deficiencies with CSC reports, requirements for CSIs, CS area inspections, and pharmacy inspections. Pharmacy managers and staff reported that the national shortage of injectable opioid pain medications did not impact needed treatment and care of their patients.

Controlled Substance Coordinator Reports

VHA requires the CSC to provide the Director with a monthly summary of findings, including discrepancies and vulnerabilities, identified during monthly CS inspections and quarterly trend reports. This facilitates timely communication of CS issues and implementation of appropriate actions to reduce organizational risks.[69] Of the 12 monthly inspection reports reviewed, the OIG found that five monthly reports (May to September 2017) were not completed. As a result, two of the four quarterly trend reports were not completed. Failure to report CS program issues may cause a delay in responding to critical issues and puts the Facility at risk for diversion activities. The CSC, appointed in October 2017, was aware of the deficiency and acknowledged a lack of program oversight.

Recommendation 11

11. The Facility Director ensures that the Controlled Substance Coordinator completes monthly summary of findings and quarterly trend reports and monitors compliance.

Facility concurred.

Target date for completion: April 2019

Facility response: In June 2018, the Corporate Compliance Officer (CCO), who supervises the Controlled Substance Inspection Coordinator (CSIC), implemented a requirement that the Monthly Summary of Findings be completed by the CSIC and sent to the CCO by the 5th working day of the month for the previous month's report. The process also requires that the Quarterly Trend Report be completed by the CSIC and sent to the CCO by the 15th of the month following the end of the quarter. It will be the responsibility of the CCO to ensure that the reports

[69] VHA Directive 1108.02(1).

are sent to the Director and other interested parties: the 10th of the month for the monthly report and the 21st of the month following the end of each quarter for the quarterly trend report. The CCO will monitor until 95% compliance is maintained for 6 consecutive months for the monthly report and 2 consecutive quarters for the quarterly report. As of October 2018, performance has not met established goals. A target completion date for full performance is April 2019.

Controlled Substances Inspectors: Appointment Letter

VHA requires that the Director appoint, by email or memo, an adequate number of CSIs to a term not to exceed three years.[70] This ensures that the term of the appointment is clear and trackable and that the collateral duties can be periodically rotated among CSI staff. The OIG found that 2 of the 10 CSIs had no written appointment email or memo from the Director. This resulted in CSIs conducting inspections without written authorization. The CSC acknowledged a lack of program oversight as the reason for noncompliance.

Recommendation 12

12. The Facility Director ensures that Controlled Substances Inspectors are appointed in writing prior to performing inspector duties and monitors compliance.

Facility concurred.

Target date for completion: April 2019

Facility response: The CSIC will ensure that appointment letters are signed before the CSI conducts an inspection. As of June 2018, all inspectors had appointment letters signed by the Director. Random monitoring was conducted by the CCO from July through September. There was an additional failure identified in October, wherein the appointment letter of an inspector could not be located. In October 2018, the CCO implemented a process which requires the CSIC to certify that appointment letters are in place prior to communicating the inspection assignments to CSIs. Monitoring will be conducted by the CCO on a monthly basis until 95% compliance is maintained for 6 consecutive months.

Controlled Substances Area Inspections: Monthly Inspections

VHA requires CSIs to conduct monthly inspections of CS storage areas.[71] The monthly inspection provides the opportunity to identify any potential drug diversion activities and discrepancies with refilling or returning CS. In 3 of the 10 areas selected for review, the OIG noted that 7 of the 18 required monthly inspections were not completed. Failure to perform

[70] VHA Directive 1108.02(1).
[71] VHA Directive 1108.02(1).

monthly inspections puts the Facility at risk for diversion activities. The CSC acknowledged competing priorities and a lack of program oversight as the reasons for noncompliance.

Recommendation 13

13. The Facility Director ensures that Controlled Substances Inspectors complete routine monthly controlled substances inspections and monitors compliance.

Facility concurred.

Target date for completion: February 2019

Facility response: Corrective action was taken immediately by the CCO communicating to the CSIC and the CSIC communicating with CSIs regarding the requirements to complete inspection, and notification requirements if inspections are not completed by the assigned date. In June 2018, the assignment process was revised to require that the CSIC complete CSI assignments at least 3 working days before beginning of each month and notify the CCO when the assignments are completed. As increased oversight, the CSIC must report to the Corporate Compliance Officer the status of inspection completions by the 15th of the month and update daily until all inspections are complete. Any inspections not completed 3 days before the end of the month will be completed by the CSIC or Alternate CSIC before the end of the month. The CCO will monitor monthly until 95% compliance is maintained for 6 consecutive months.

Pharmacy Inspections: Verification of Drugs Held for Destruction

VHA requires that, during monthly CS inspections, the CSI is to verify there is a corresponding sealed evidence bag containing drug(s) for each medication held for destruction listed on the "Destructions File Holding Report."[72] At the Waco inpatient pharmacy, the OIG did not find evidence in four of the six months reviewed that CSIs verified drugs held for destruction. This resulted in a potential vulnerability for the Facility. The CSC acknowledged that a lack of program oversight resulted in noncompliance.

Recommendation 14

14. The Facility Director ensures that Controlled Substances Inspectors verify drugs held for destruction during monthly inspections at the Waco inpatient pharmacy and monitors compliance.

Facility concurred.

Target date for completion: January 2019

[72] VHA Directive 1108.02(1).

Facility response: The specific issue was the documentation of the inspection of Drugs Held for Destruction portion of three Pharmacy locations. That element of the inspection was being completed, but the necessary documentation was not maintained. During the CHIP review, the CSIC formally communicated to all inspectors and applicable Pharmacy Staff regarding documentation requirements for Drugs Awaiting Destruction. In June 2018, the CSIC's process of reviewing inspection documentation was enhanced. The new process requires that the CSIC ensure, upon receipt of inspection documentation, that all required elements of the inspection have been completed and that all necessary documentation was provided. Compliance since June 1, 2018, has been 95%. The CCO will monitor until 95% compliance is maintained for 6 consecutive months.

Pharmacy Inspections: Prescription Pad Accountability

VHA requires CSIs to verify the inventory count of prescription pads on the day of the monthly pharmacy inspection.[73,74] This process identifies CS vulnerabilities and reduces the risk of drug diversion activities. At the Waco outpatient pharmacy, the OIG noted that CSIs did not verify prescription pads inventory count for the six months of inspection reports reviewed. This resulted in a potential vulnerability in the accountability for CS. The CSC cited a lack of program oversight for noncompliance.

Recommendation 15

15. The Facility Director ensures Controlled Substances Inspectors complete pharmacy prescription pad inventories during monthly pharmacy inspections at the Waco outpatient pharmacy and monitors compliance.

Facility concurred.

Target date for completion: May 2019

Facility response: Prior to June 1, 2018, this was being reviewed, but no documentation was provided to verify compliance. In June 2018, the CSIC's process of reviewing inspection documentation was enhanced. The new process requires that the CSIC ensure, upon receipt of inspection documentation, that all required elements of the inspection have been completed and that all necessary documentation was provided. Compliance since June 1, 2018, has been 100%. The CCO will monitor until 95% compliance is maintained for 6 consecutive months. The target date is January 2019.

Additionally, the CSIC will provide face-to-face training on all inspection processes upon an inspector's appointment and ensure competency before allowing the inspector to conduct

[73] VHA Directive 1108.02(1).
[74] VHA Directive 1108.05, *Outpatient Pharmacy Services*, June 16, 2016.

inspections alone. The CSIC will accompany new inspectors to certify the Initial Competency. The CCO will monitor until 95% compliance is maintained for 6 consecutive months. The target date is April 2019.

Pharmacy Inspections: Verification of Hard Copy Prescriptions

VHA requires that during CS area inspections, CSIs verify for evidence of a written prescription for non-electronic CS orders.[75] This provides accountability for CS dispensed from the pharmacy. At the Temple outpatient pharmacy, the OIG noted that CSIs did not verify written CS orders for two of six months of inspection reports reviewed. Failure to verify orders may cause a delay in identifying any potential drug diversion activities. The CSC acknowledged a lack of oversight as the reason for noncompliance.

Recommendation 16

16. The Facility Director ensures that Controlled Substances Inspectors verify evidence of written prescriptions for non-electronic controlled substance orders during monthly area inspections at the Temple outpatient pharmacy and monitors compliance.

Facility concurred.

Target date for completion: January 2019

Facility response: The CSIC's process of reviewing inspection documentation has been enhanced. The CSIC will ensure, upon receipt of inspection documentation, that all required elements of the inspection have been completed and that all necessary documentation is provided. This includes verification of written prescriptions for non-electronic controlled substance orders (e.g. verbal orders). The CSIC will provide face-to-face training on inspection processes upon an inspector's appointment and ensure competency before allowing the inspector to conduct inspections alone. By December 31, 2018, the CSIC will provide face-to-face training on CS inspection procedures to all current CSICs. Monitoring will be accomplished by an audit to be completed by the CCO in January 2019. 95% compliance is required.

[75] VHA Directive 1108.02(1).

Mental Health: Posttraumatic Stress Disorder Care

Posttraumatic Stress Disorder (PTSD) 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."[76] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[77] 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.[78] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[79]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 46 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer to patient of further diagnostic evaluation

[76] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017).

[77] VHA Handbook 1160.03.

[78] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

[79] Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

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

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[80] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[81] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[82]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[83] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[84] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[85]

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 47 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Provision of or access to GE
- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board
- Provision of clinical care
  - Medical evaluation by GE provider
  - Assessment by GE nurse

[80] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[81] VHA Directive 1140.04.

[82] Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

[83] Public Law 106-117.

[84] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[85] VHA Directive 1140.04.

  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on GE
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

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

Women's Health: Mammography Results and Follow-up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[86] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[87] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[88]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.[89]

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 49 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient

[86] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (Website accessed on May 18, 2017.)

[87] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (Handbook rescinded and replaced with VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018).

[88] Veterans Health Care Act of 1992, Title I, Publ L. 102-585 (1992).

[89] VHA Directive 1330.01, (2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018).

- Performance of follow-up mammogram if indicated
- Performance of follow-up study[90]

Conclusion

Generally, the OIG noted compliance with requirements for electronic linking of mammogram results, scanning hard copy reports if outsourced, inclusion of required components in reports, communication of results and any recommended course of action to the ordering provider, and performance of follow-up mammograms and studies if indicated. However, the OIG identified a deficiency with communication of results to patients.

Communication of Results to Patients

VHA requires that ordering providers or designees notify patients of mammography results.[91] Consistent communication of test results is essential to ensure safe and effective health care. The OIG estimated that providers communicated results to patients in 69 percent of the EHRs reviewed; and, 95 percent of the time, the true compliance rate is between 55.1 and 81.6 percent, which is statistically significantly below the 90 percent benchmark.[92] Failure to notify patients of results could lead to delays in treatment. Program managers were aware they had inconsistent patient notification processes and reported implementing a new standardized notification method.

Recommendation 17

17. The Chief of Staff ensures providers or designees communicate mammogram results to patients and monitors compliance.

Facility concurred.

Target date for completion: March 2019

Facility response: The Women's Health Care Coordinator for Preventive Care (WHCC-PC), in collaboration across services, implemented an internal system for surveillance of CPRS [Computerized Patient Record System] documentation to ensure timely notifications of results. The "Communication Safety Net" process entails a monthly chart audit of mammogram notifications from provider/designee to patient. Chart audits are completed on 90% of mammograms ordered. Implementation of a standard communication process was also established whereby WHCC-PC provides a written alert of mammogram result notification non-compliance to WH- PACT staff. An ongoing Lean Six Sigma project for mammogram

[90] This performance indicator did not apply to this Facility.
[91] VHA Directive 1330.01.

notification was initiated in March 2018 and is in its final steps. Compliance rate of timely notification has already shown significant improvement: May = 59%; June = 71%; July = 97%; and August = 97%. This will be monitored by the WHCC-PC until 90%, or greater, compliance is achieved for a minimum of six consecutive months, or two quarters, and reported to the Chief of Staff and Clinical Executive Committee.

High-risk Processes: Central Line-associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[93] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[94] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[95]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[96]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[97] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.[98]

The OIG's review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 10 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

- Presence of Facility policy on the use and care of central lines

[93] TJC. Infection Prevention and Control standard IC.01.03.01.

[94] Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

[95] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

[96] The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

[97] The Centers for Disease Control and Prevention National Healthcare Safety Network, Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection, January 2017.

[98] Association for Professionals in Infection Control and Epidemiology, 2015.

- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients and families
- Use of a checklist for central line insertion and maintenance

Conclusion

The OIG noted that the Facility met the requirements related to use and care of central lines policy, performance of an annual infection prevention risk assessment, routine discussion of CLABSI data, provision of education materials, and the use of a checklist for central line insertion and maintenance. However, the OIG identified a deficiency with registered nurses' CLABSI education.

Staff Education

TJC requires that all clinical staff involved in the insertion and maintenance of central lines receive CLABSI prevention education upon hire or granting of initial privileges and periodically thereafter.[99] The OIG found no evidence of the required education for 7 of 10 registered nurses reviewed. Failure to educate staff may result in increased incidence of CLABSI. Clinical leaders were aware of the requirement but believed nursing competency assessments met the training requirement.

Recommendation 18

18. The Associate Director for Patient Care Services ensures that all registered nurses involved in managing central lines receive the required central line-associated bloodstream infection prevention education and monitors compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: A training course including CLABSI training was standardized for use in Nursing Orientation and for annual education. The course was assigned to all registered nurses that manage central lines in ICU, ED, 2K, 3J, 3K, 4K, Oncology Clinic, Temple CLC,

[99] TJC. National Patient Safety Goals: NPSG.07.04.01.

DPP/PACU and OR/Cath Lab. Training will be completed for 100% of the current registered nurses in these areas by November 30, 2018. Ongoing monitoring will be conducted through TMS [Talent Management System] to ensure continued compliance.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Eighteen OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, ADPCS, Associate Director, Assistant Director–Austin, and Assistant Director–Waco. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• None
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Service Chiefs present the results of completed FPPEs to the Medical Staff Executive Council. • Service Chiefs include service-specific data in OPPEs. • The Chief, Pathology and Laboratory Medicine Service, includes the required pathology-specific criteria in pathology practitioners' OPPEs.	• FPPEs include clearly delineated timeframes.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	  ○ EOC rounds and deficiency tracking
	  ○ Infection prevention
	  ○ General safety
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• CBOC
	  ○ General safety
	  ○ Medication safety and security
	  ○ Infection prevention
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• Locked MH Unit
	  ○ Bi-annual MH EOC rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency Management
	  ○ Hazard Vulnerability Analysis (HVA)
	  ○ Emergency Operations Plan (EOP)
	  ○ Emergency power testing and availability
		• Personal protective equipment is readily accessible.
		• Prescribed sleep apnea equipment is furnished timely to patients.
		• VA Police and Security Service regularly test panic alarms and take follow-up actions for identified deficiencies at the Austin CBOC.
		• VA Police and Security Service regularly test panic alarms and take follow-up actions for identified deficiencies at the Waco campus locked mental health unit.
			• A clean environment is maintained throughout the Facility.
			• The Facility's EOP is reviewed annually by the Emergency Management Committee.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• The CSC completes CS monthly summary of findings and quarterly trend reports. • CSIs complete routine monthly CS inspections. • CSIs verify CS drugs held for destruction during monthly inspections at the Waco inpatient pharmacy. • CSIs complete pharmacy prescription pad inventories during monthly pharmacy inspections at the Waco outpatient pharmacy. • CSIs verify evidence of written prescriptions for non-electronic CS orders during monthly area inspections at the Template outpatient pharmacy.	• CSIs are appointed in writing prior to performing inspector duties.
Mental Health: Posttraumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-term Care: Geriatric Evaluations	• Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Mammography Results and Follow-up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• Providers or designees communicate mammogram results to patients.	• None
High-risk Processes: Central Line-associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials • Policy, procedure, and checklist for insertion and maintenance of central venous catheters	• None	• Registered nurses involved in managing central lines receive the required CLABSI prevention education.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high-complexity (1a)[100] affiliated[101] Facility reporting to VISN 17.

Table 7. Facility Profile for Temple (674)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[102]	Facility Data FY 2016[103]	Facility Data FY 2017[104]
Total Medical Care Budget in Millions	$639.1	$723.1	$730.6
Number of:			
• Unique Patients	98,998	103,396	104,597
• Outpatient Visits	1,172,423	1,177,553	1,234,106
• Unique Employees[105]	3,201	3,329	3,557
Type and Number of Operating Beds:			
• Blind Rehabilitation	11	11	11
• Community Living Center	210	210	210
• Domiciliary	332	278	252
• Medicine	79	79	79
• Mental Health	34	34	34
• Residential Rehabilitation	9	9	9
• Surgery	21	21	21
Average Daily Census:			
• Blind Rehabilitation	9	8	9
• Community Living Center	158	145	145

[100] The VHA medical centers are classified according to a facility complexity model; 1a designation indicates a Facility with high volume, high-risk patients, most complex clinical programs, and large research and teaching programs.

[101] Associated with a medical residency program.

[102] October 1, 2014, through September 30, 2015.

[103] October 1, 2015, through September 30, 2016.

[104] October 1, 2016, through September 30, 2017.

[105] Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2015[102]	Facility Data FY 2016[103]	Facility Data FY 2017[104]
• Domiciliary	211	194	198
• Medicine	60	57	51
• Mental Health	23	28	27
• Residential Rehabilitation	6	7	6
• Surgery	11	13	11

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

VA Outpatient Clinic Profiles[106]

The VA outpatient clinics in 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 8 provides information relative to each of the clinics.

Table 8. VA Outpatient Clinic Workload/Encounters[107] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[108] Provided	Diagnostic Services[109] Provided	Ancillary Services[110] Provided
Brownwood, TX	674GB	9,553	2,131	Cardiology Dermatology Endocrinology Pulmonary/ Respiratory	EKG Laboratory and Pathology Radiology	Nutrition Pharmacy Social Work Weight Management
Cedar Park, TX	674GD	13,885	4,051	Cardiology Dermatology Endocrinology	EKG Laboratory and Pathology Radiology	Pharmacy Social Work Weight Management Nutrition

[106] Includes all outpatient clinics in the community that were in operation as of February 15, 2018.

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

[108] Specialty care services refer to non-PC and non-MH services provided by a physician.

[109] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

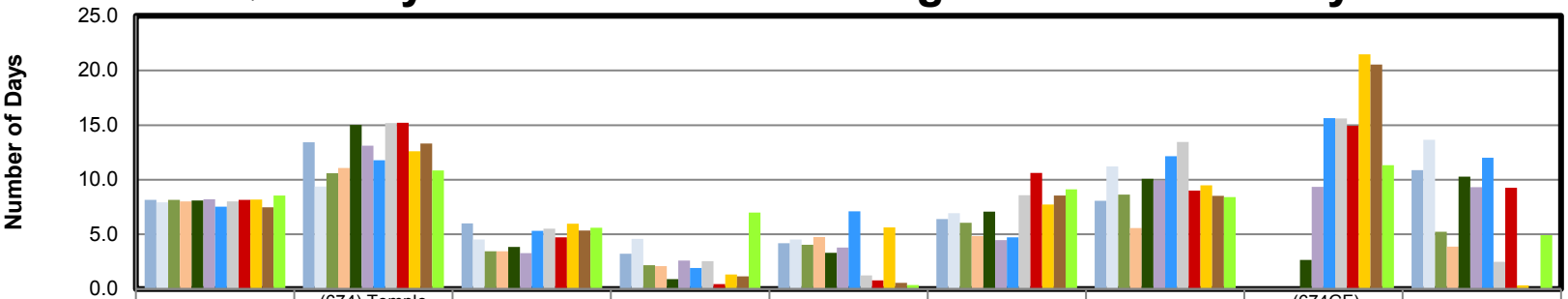
[110] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[108] Provided	Diagnostic Services[109] Provided	Ancillary Services[110] Provided
College Station, TX	674GC	11,976	3,545	Cardiology Dermatology Endocrinology Vascular	EKG Laboratory and Pathology Radiology	Nutrition Pharmacy Social Work Weight Management
LaGrange, TX	674HB	3,020	277	Endocrinology	EKG Laboratory and Pathology	Nutrition Pharmacy
Palestine, TX	674GA	7,486	1,399	Cardiology Dermatology Endocrinology Vascular	EKG Laboratory and Pathology Radiology	Nutrition Pharmacy Social Work Weight Management
Temple, TX	674GF	2,127	164	n/a	n/a	Pharmacy Social Work Weight Management Nutrition

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[108] Provided	Diagnostic Services[109] Provided	Ancillary Services[110] Provided
Austin, TX	674BY	56,247	35,973	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Poly-Trauma Rehab Physician Anesthesia Eye GYN Neurosurgery Orthopedics Otolaryngology Plastic Podiatry Urology	EKG Laboratory and Pathology Radiology	Nutrition Pharmacy Prosthetics Social Work Weight Management Dental

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[111]



	VHA Total	(674) Temple, TX (Olin E. Teague Center)	(674BY) Austin, TX	(674GA) Palestine, TX	(674GB) Brownwood, TX	(674GC) Bryan, TX	(674GD) Cedar Park, TX	(674GF) Temple-General Bruce Drive, TX	(674HB) LaGrange, TX
APR-FY17	8.2	13.4	6.0	3.2	4.2	6.4	8.1	n/a	10.9
MAY-FY17	7.9	9.4	4.5	4.6	4.5	6.9	11.2	n/a	13.7
JUN-FY17	8.2	10.6	3.4	2.2	4.1	6.0	8.6	n/a	5.3
JUL-FY17	8.0	11.1	3.5	2.1	4.8	4.8	5.6	n/a	3.9
AUG-FY17	8.1	15.0	3.9	0.9	3.3	7.1	10.1	2.7	10.3
SEP-FY17	8.2	13.1	3.3	2.6	3.8	4.5	9.9	9.4	9.3
OCT-FY18	7.5	11.8	5.3	1.9	7.1	4.7	12.1	15.6	12.0
NOV-FY18	8.0	15.2	5.5	2.5	1.3	8.6	13.4	15.6	2.5
DEC-FY18	8.1	15.2	4.7	0.4	0.8	10.6	9.0	14.9	9.3
JAN-FY18	8.2	12.6	6.0	1.3	5.6	7.7	9.5	21.5	0.3
FEB-FY18	7.5	13.3	5.4	1.2	0.6	8.6	8.5	20.5	0.0
MAR-FY18	8.6	10.9	5.6	7.0	0.4	9.1	8.4	11.3	4.9

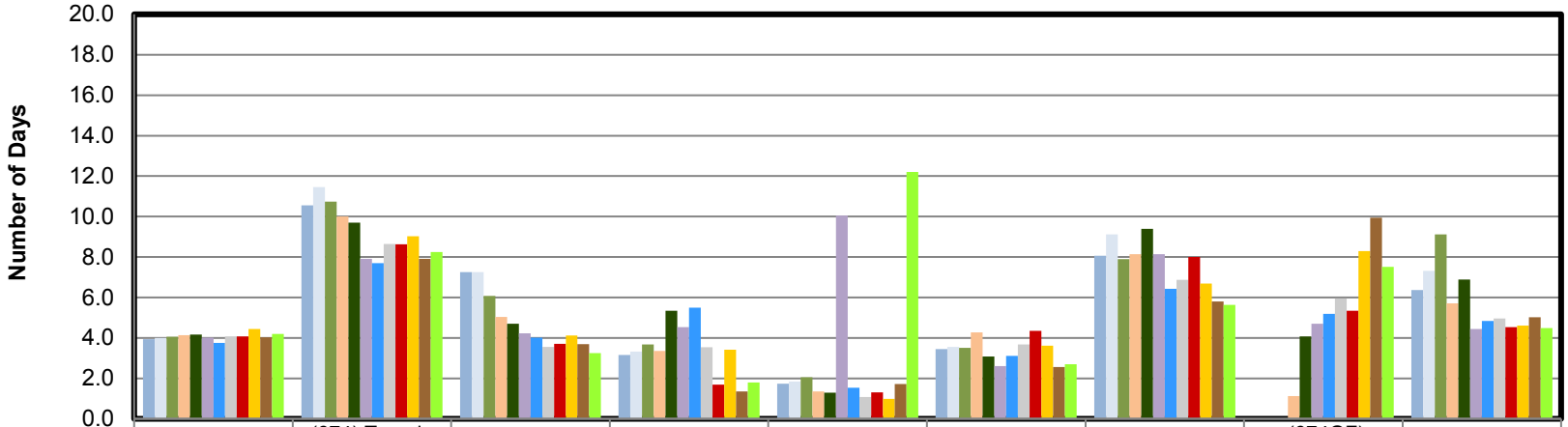
Source: VHA Support Service Center

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

***Data Definition**: The average number of calendar days between 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. The absence of reported data is indicated by "n/a."*

[111] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

Quarterly Established PC Patient Average Wait Time in Days

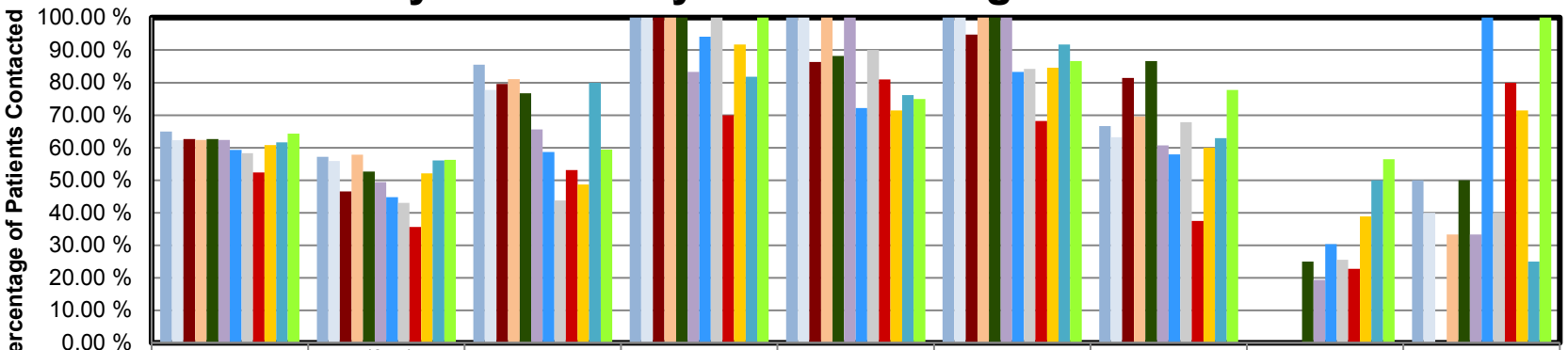


	VHA Total	(674) Temple, TX (Olin E. Teague Center)	(674BY) Austin, TX	(674GA) Palestine, TX	(674GB) Brownwood, TX	(674GC) Bryan, TX	(674GD) Cedar Park, TX	(674GF) Temple-General Bruce Drive, TX	(674HB) LaGrange, TX
APR-FY17	3.9	10.6	7.3	3.2	1.7	3.5	8.1	n/a	6.4
MAY-FY17	4.0	11.5	7.2	3.3	1.8	3.6	9.1	0.0	7.3
JUN-FY17	4.1	10.7	6.1	3.7	2.1	3.5	7.9	0.0	9.1
JUL-FY17	4.1	10.0	5.0	3.4	1.4	4.3	8.1	1.1	5.7
AUG-FY17	4.2	9.7	4.7	5.3	1.3	3.1	9.4	4.1	6.9
SEP-FY17	4.0	7.9	4.2	4.5	10.1	2.6	8.1	4.7	4.4
OCT-FY18	3.7	7.7	4.0	5.5	1.5	3.1	6.4	5.2	4.8
NOV-FY18	4.1	8.7	3.5	3.5	1.1	3.7	6.9	6.0	5.0
DEC-FY18	4.1	8.6	3.7	1.7	1.3	4.4	8.0	5.3	4.5
JAN-FY18	4.4	9.0	4.1	3.4	1.0	3.6	6.7	8.3	4.6
FEB-FY18	4.0	7.9	3.7	1.4	1.7	2.6	5.8	9.9	5.0
MAR-FY18	4.2	8.3	3.3	1.8	12.2	2.7	5.6	7.5	4.5

Source: VHA Support Service Center

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

Data Definition: *The average number of calendar days between an established patient's 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. The absence of reported data is indicated by "n/a."*

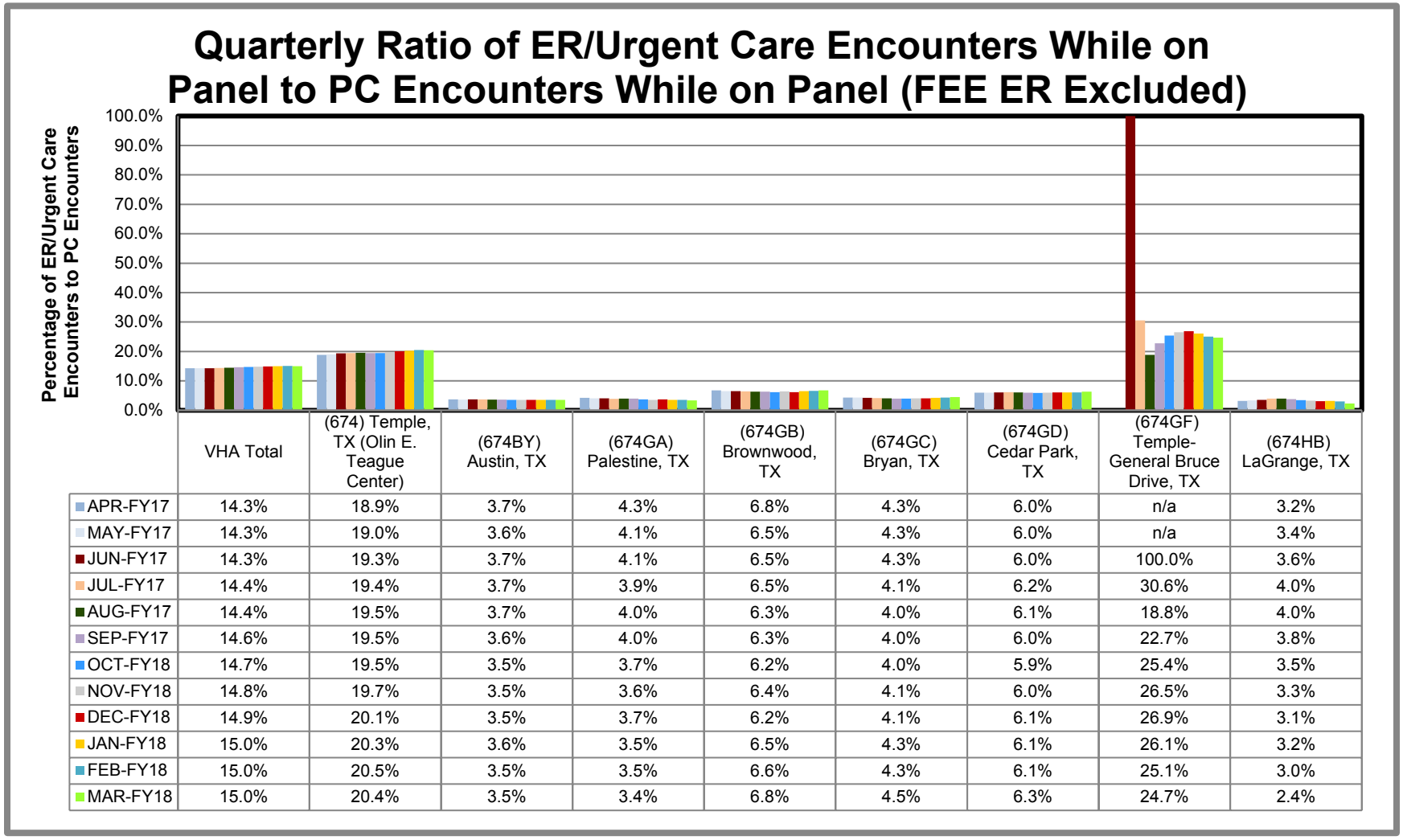


	All VHA	(674) Temple, TX (Olin E. Teague Center)	(674BY) Austin, TX	(674GA) Palestine, TX	(674GB) Brownwood, TX	(674GC) Bryan, TX	(674GD) Cedar Park, TX	(674GF) Temple-General Bruce Drive, TX	(674HB) LaGrange, TX
APR-FY17	65.00 %	57.20 %	85.56 %	100.00 %	100.00 %	100.00 %	66.67 %	n/a	50.00 %
MAY-FY17	62.30 %	55.88 %	77.78 %	100.00 %	100.00 %	100.00 %	63.16 %	n/a	40.00 %
JUN-FY17	62.66 %	46.58 %	79.57 %	100.00 %	86.36 %	94.74 %	81.48 %	n/a	0.00 %
JUL-FY17	62.41 %	57.83 %	81.05 %	100.00 %	100.00 %	100.00 %	69.57 %	0.00 %	33.33 %
AUG-FY17	62.61 %	52.69 %	76.74 %	100.00 %	88.24 %	100.00 %	86.67 %	25.00 %	50.00 %
SEP-FY17	62.33 %	49.41 %	65.63 %	83.33 %	100.00 %	100.00 %	60.71 %	19.35 %	33.33 %
OCT-FY18	59.35 %	44.75 %	58.70 %	94.12 %	72.22 %	83.33 %	57.89 %	30.36 %	100.00 %
NOV-FY18	58.25 %	42.98 %	43.75 %	100.00 %	90.00 %	84.21 %	67.86 %	25.53 %	40.00 %
DEC-FY18	52.40 %	35.66 %	53.09 %	70.00 %	80.95 %	68.18 %	37.50 %	22.73 %	80.00 %
JAN-FY18	60.82 %	52.12 %	48.68 %	91.67 %	71.43 %	84.62 %	60.00 %	38.89 %	71.43 %
FEB-FY18	61.66 %	56.03 %	80.00 %	81.82 %	76.19 %	91.67 %	62.96 %	50.00 %	25.00 %
MAR-FY18	64.30 %	56.25 %	59.38 %	100.00 %	75.00 %	86.67 %	77.78 %	56.41 %	100.00 %

Source: VHA Support Service Center

Note: The OIG 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 two business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within two 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. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17." The absence of reported data is indicated by "n/a."*



	VHA Total	(674) Temple, TX (Olin E. Teague Center)	(674BY) Austin, TX	(674GA) Palestine, TX	(674GB) Brownwood, TX	(674GC) Bryan, TX	(674GD) Cedar Park, TX	(674GF) Temple-General Bruce Drive, TX	(674HB) LaGrange, TX
APR-FY17	14.3%	18.9%	3.7%	4.3%	6.8%	4.3%	6.0%	n/a	3.2%
MAY-FY17	14.3%	19.0%	3.6%	4.1%	6.5%	4.3%	6.0%	n/a	3.4%
JUN-FY17	14.3%	19.3%	3.7%	4.1%	6.5%	4.3%	6.0%	100.0%	3.6%
JUL-FY17	14.4%	19.4%	3.7%	3.9%	6.5%	4.1%	6.2%	30.6%	4.0%
AUG-FY17	14.4%	19.5%	3.7%	4.0%	6.3%	4.0%	6.1%	18.8%	4.0%
SEP-FY17	14.6%	19.5%	3.6%	4.0%	6.3%	4.0%	6.0%	22.7%	3.8%
OCT-FY18	14.7%	19.5%	3.5%	3.7%	6.2%	4.0%	5.9%	25.4%	3.5%
NOV-FY18	14.8%	19.7%	3.5%	3.6%	6.4%	4.1%	6.0%	26.5%	3.3%
DEC-FY18	14.9%	20.1%	3.5%	3.7%	6.2%	4.1%	6.1%	26.9%	3.1%
JAN-FY18	15.0%	20.3%	3.6%	3.5%	6.5%	4.3%	6.1%	26.1%	3.2%
FEB-FY18	15.0%	20.5%	3.5%	3.5%	6.6%	4.3%	6.1%	25.1%	3.0%
MAR-FY18	15.0%	20.4%	3.5%	3.4%	6.8%	4.5%	6.3%	24.7%	2.4%

Source: VHA Support Service Center

Note: The OIG 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 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. The absence of reported data is indicated by "n/a."*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[112]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	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
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[112] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed February 14, 2018.

Measure	Definition	Desired Direction
HC Assoc Infections	Healthcare associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	A higher value is better than a lower value
MH Wait Time	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
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (PCMH)	A higher value is better than a lower value
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
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Rating SC Provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 26, 2018

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

Subj: CHIP Review of the Central Texas Veterans Health Care System, Temple, TX

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

I concur with the findings and recommendations in the draft report and support the Central Texas VA Health Care System's efforts in their submitted action plan.

Thank you,

(Original signed by:)

Wendell Jones, MD

for

Jeff Milligan

VISN 17 Director

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

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 22, 2018

From: Director, Central Texas Veterans Health Care System (674/00)

Subj: CHIP Review of the Central Texas Veterans Health Care System, Temple, TX

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

I concur with all of the findings and recommendations in the draft report. The Central Texas Veterans Health Care System is in the process of completing the action plan.

(Original signed by:)

Amy Maynard

For and in the absence of

Christopher R. Sandles, MBA, FACHE
Director

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

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