DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Amarillo VA Health Care System

Texas

CHIP REPORT | REPORT #19-00007-168 | JULY 24, 2019

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Figure 1. *Amarillo VA Health Care System, Texas (Source: https://vaww.va.gov/directory/guide/, accessed on April 15, 2019)*

Abbreviations

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

Report Overview

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

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

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

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

This unannounced visit was conducted during the week of January 14, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

The facility leadership team consists of the director, chief of staff, associate director for Patient Care Services (ADPCS, also referred locally as nurse executive), and associate director (primarily nonclinical). Organizational communications and accountability are managed through a committee reporting structure, with the Executive Health Care Council having oversight for several working groups. The director and chief of Quality are co-chairs of the Quality Safety Value Board, which is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes.

At the time of the OIG's visit, the facility's leadership team had been working together since July 22, 2018, the date when the chief of staff was permanently assigned. The director and associate director were permanently assigned in November 2015 and November 2014, respectively. The ADPCS has been in the position since October 2009.

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

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors.

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.[2] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics and SAIL community living center (CLC) measures, the leaders should continue to take

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

[2] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 6, 2019, but is not accessible to the public.)

actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "4-star" and CLC "2-star" quality ratings.[3]

The OIG noted findings of deficiencies in six of the eight clinical areas reviewed and issued 19 recommendations that are attributable to the director, chief of staff, and associate director. These are briefly described below.

Quality, Safety, and Value

The OIG team found there was general compliance with requirements for protected peer reviews and patient safety. However, the team identified concerns with the lack of participation in interdisciplinary reviews of utilization management data and incomplete analysis and trending of resuscitation episodes.[4]

Medical Staff Privileging

The facility complied with the requirements for focused professional practice evaluation for cause. However, the OIG identified noncompliance with selected requirements for the privileging, focused professional practice evaluation, and ongoing professional practice evaluation processes.[5]

Environment of Care

Generally, the OIG team found many of the performance indicators were achieved and did not note any issues with the availability of medical equipment and supplies at the parent facility and representative community based outpatient clinic. However, the team found expired and unlabeled medications, clean and soiled equipment and supplies stored together, and a deficiency with the testing of the emergency power outlets at the parent facility.

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

[4] The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the "forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria."

[5] The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, "*Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*," July 2016 (Revision 2). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility." A focused professional practice evaluation for cause is "a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the provider's privileges."

Mental Health

Generally, the OIG team found compliance with many of the performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, referral for MST-related care, and provision of clinical care. The team noted lack of compliance with requirements that the MST coordinator monitors MST-related staff training and communicates issues with leaders and that providers complete MST mandatory training within the required timeframe.

Geriatric Care

The inspection revealed providers followed requirements for justifying the reason for medication initiation, reconciling patient's medications, and documenting adverse drug reactions. However, the OIG identified inadequate patient and/or caregiver education specific to the newly prescribed antidepressant drug.

Women's Health

Overall, the OIG team found the facility attained many of the performance indicators, including those related to requirements for a designated women veterans program manager and clinical champion, clinical oversight of the women's health program, and follow-up care when indicated. The team noted concerns with the Women Veterans Health Committee membership, tracking data related to cervical cancer screenings, and communicating results to patients within the required timeframe.

Summary

In reviewing key healthcare processes, the OIG issued 19 recommendations for improvement directed to the facility director, chief of staff, and associate director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 74–75, 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 for the open recommendations until they are completed.

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Contents

Purpose and Scope

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

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

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

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

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

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

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[8]

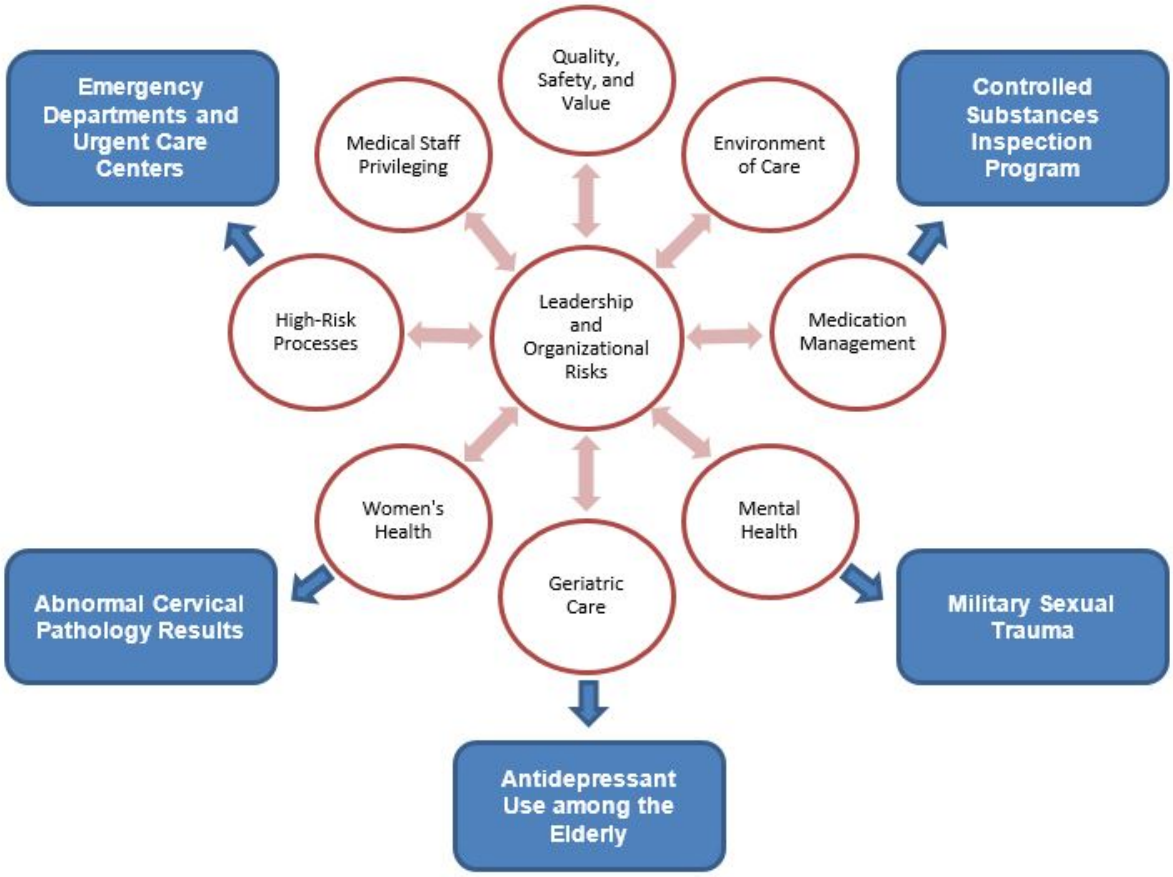

Figure 2. *FY 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

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

Methodology

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

The inspection period examined operations from March 26, 2016, through January 18, 2019, the last day of the unannounced week-long site visit.[10]

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

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 reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

Executive Leadership Position Stability and Engagement

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

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

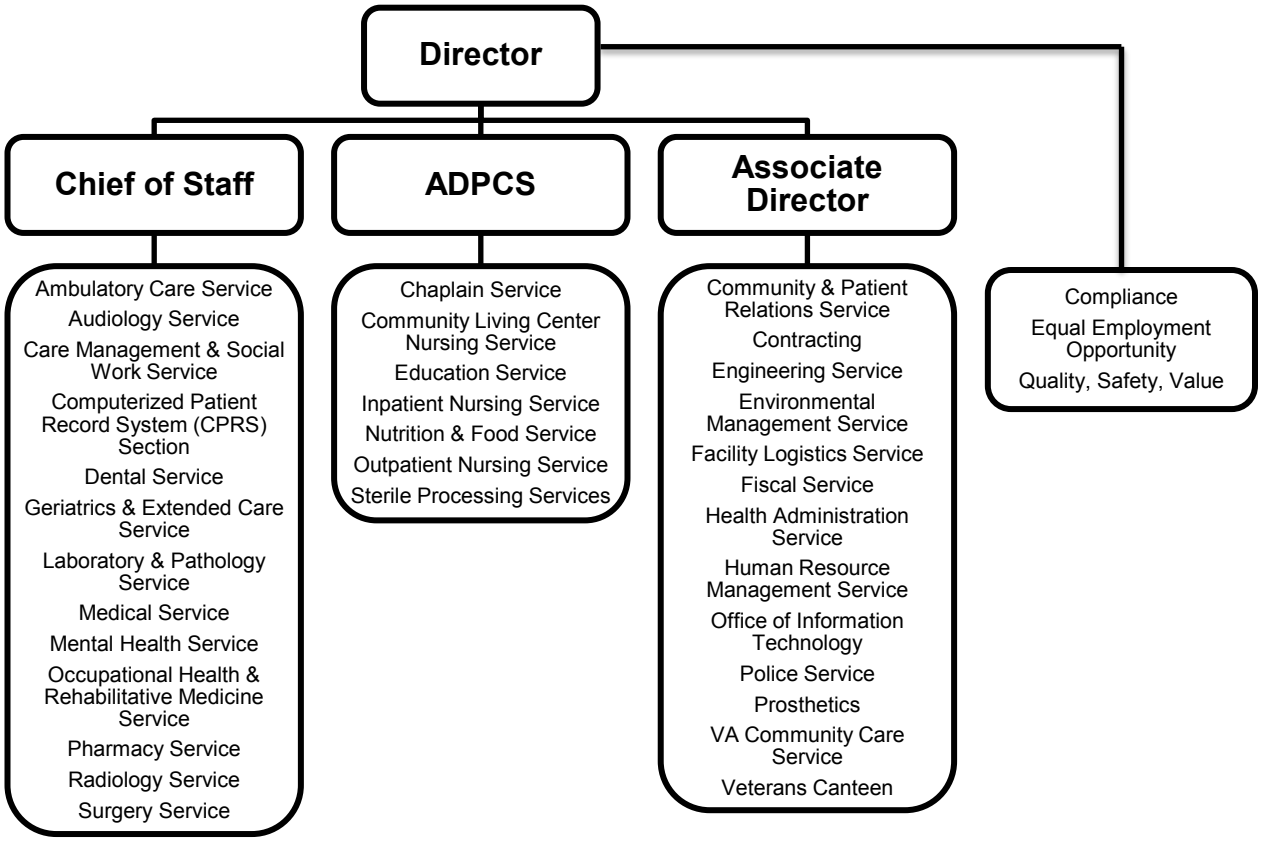

Figure 3. *Facility Organizational Chart*[12]
Source: Amarillo VA Health Care System (received January 14, 2019)

At the time of the OIG site visit, the executive team had been working together for six months, although several team members have been in their position for over three years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	November 1, 2015
Chief of staff	July 22, 2018
Associate director for Patient Care Services	October 13, 2009
Associate director	November 2, 2014

Source: Amarillo VA Health Care System human resources officer (received January 14, 2019)

[12] At this facility, the director is responsible for Compliance; Equal Employment Opportunity; and Quality, Safety, Value.

To help assess facility executive leaders' engagement, 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 generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

These leaders are also engaged in monitoring patient safety and care through the Quality Safety Value Board, for which the director and chief of Quality serve as co-chairs. The Quality Safety Value Board is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes and reports to the Executive Health Care Council. The director also serves as the chairperson of the Executive Health Care Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Health Care Council oversees various working groups, such as the Administrative Executive, Patient Care, and Medical Executive Boards (see Figure 4.)

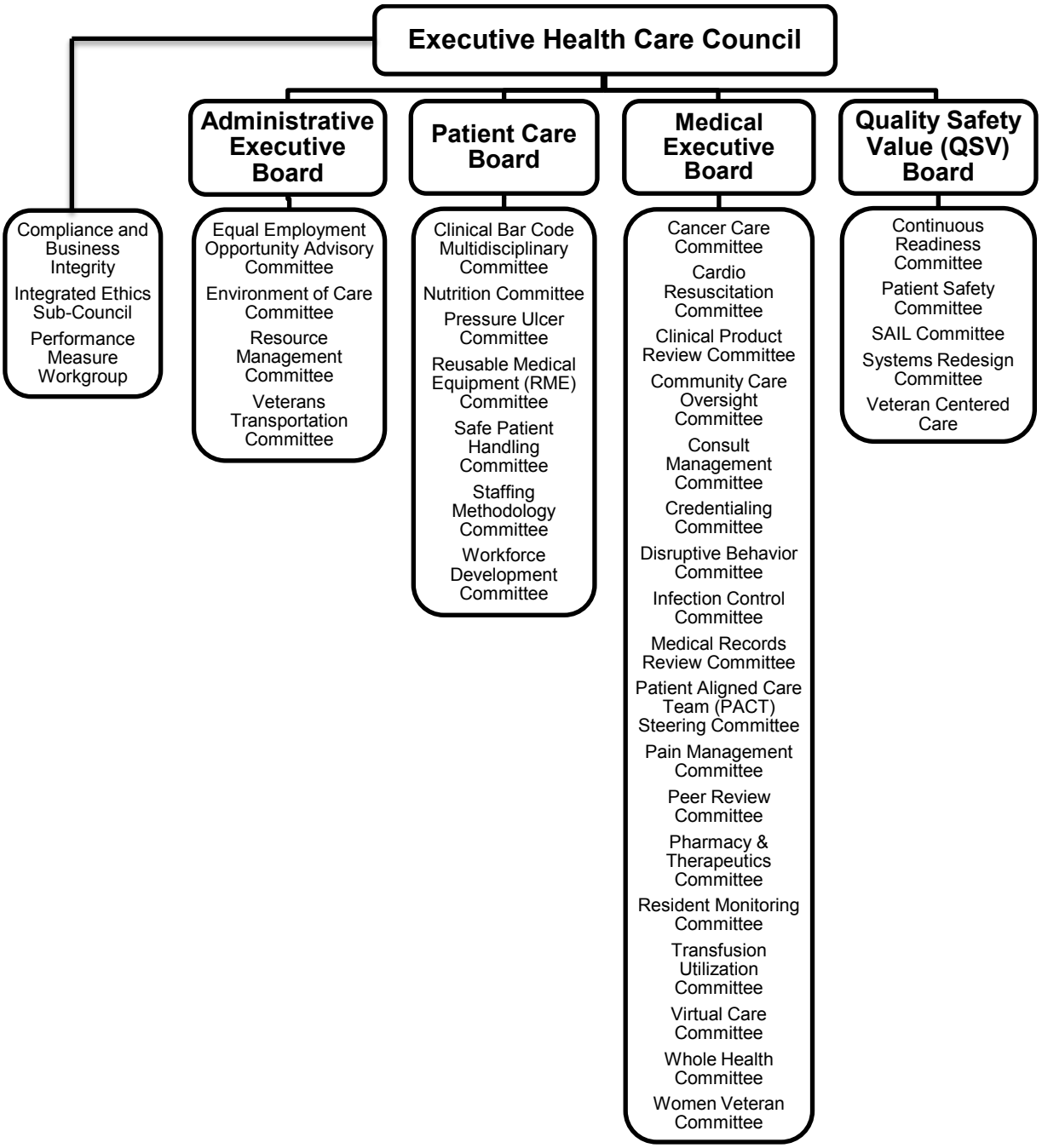

Figure 4. *Facility Committee Reporting Structure*[13]
Source: Amarillo VA Health Care System (January 14, 2019)

[13] The Executive Health Care Council oversees the Compliance and Business Integrity Committee, Integrated Ethics Sub-Council, and Performance Measure Workgroup.

Employee Satisfaction

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

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2017, through September 30, 2018.[14] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for the selected survey leadership questions was similar to or higher than the VHA average.[15] Except for the recently-appointed chief of staff, the same trend was noted for the members of the executive leadership team. In all, employees appear generally satisfied with facility leaders.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[16]	0–100 where HIGHER scores are more favorable	71.7	73.3	86.7	85.0	92.2	78.2

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.4	3.7	3.1	4.3	4.3
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.6	3.9	3.0	4.4	4.4
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.6	4.1	3.7	4.4	4.3

Source: VA All Employee Survey (accessed December 17, 2018)

Table 3 summarizes employee attitudes toward the workplace, also as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were similar to or better than the VHA average. Facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.9	4.0	4.2	4.4	4.7

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.8	3.6	4.5	4.4	4.3
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.3	1.4	1.1	0.8	1.0

Source: VA All Employee Survey (accessed December 17, 2018)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through August 31, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[17]

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

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

patients' attitudes toward facility leaders (see Table 4). For this facility, all four patient survey results reflected better care ratings than the VHA average. Patients were generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients, for example, opening a new primary care building to improve access, hiring a cardiologist, making daily leadership rounds, and using a "real time" customer feedback tool.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through August 31, 2018)

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.	66.9	67.7
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.	84.3	88.3
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.	76.2	81.4
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.	76.4	80.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 17, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[18] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[19] Indicative of effective leadership, the facility has closed all recommendations for improvement.[20]

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.[21] Additional results included the Long Term Care Institute's inspection of the facility's CLC.[22]

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

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

[20] 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.

[21] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. https://www.cap.org/about-the-cap. (The website was accessed on August 8, 2018.); In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas, Report No. 16-00118-321, June 14, 2016*)	March 2016	10	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Amarillo VA Health Care System, Amarillo, Texas, Report No. 16-00028-337, June 23, 2016*)	March 2016	10	0
OIG *(Healthcare Inspection – Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA Health Care System, Amarillo, Texas, Report No. 14-03822-289, July 6, 2017*)	August 2014 January 2015 March 2016	2	0
OIG (*Healthcare Inspection – Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA Health Care System, Amarillo, Texas, Report No. 14-03822-359, September 7, 2017*)	August 2014 January 2015 March 2016	2	0
TJC			
• Regular	February 2017		
○ Hospital Accreditation		47	0
○ Behavioral Health Care Accreditation		6	0
○ Home Care Accreditation		6	0
• Laboratory (Lubbock Clinic)	September 2018	7	0

Sources: OIG and TJC (Inspection/survey results verified with the director on January 16, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from March 26, 2016 (the prior comprehensive OIG inspection), through January 18, 2019.[23]

Table 6. Summary of Selected Organizational Risk Factors (March 26, 2016, through January 18, 2019)

Factor	Number of Occurrences
Sentinel Events[24]	0
Institutional Disclosures[25]	4
Large-Scale Disclosures[26]	0

Source: Amarillo VA Health Care System's risk manager (received January 14, 2019)

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.[27] The rates presented are specifically applicable for this facility, and lower rates

[23] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Amarillo VA Health Care System is a medium complexity (2) affiliated facility as described in Appendix B.)

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

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

[26] According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients or their personal representatives that they may have been affected by an adverse event resulting from a systems issue."

[27] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (The website was accessed on December 11, 2017.)

indicate lower risks. Table 7 summarizes patient safety indicator data from October 1, 2016, through September 30, 2018.

Table 7. Patient Safety Indicator Data (October 1, 2016, through September 30, 2018)

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 17	Facility
Pressure ulcer	0.74	0.33	0.00
Death among surgical inpatients with serious treatable conditions	113.42	75.10	0.00
Iatrogenic pneumothorax[28]	0.17	0.09	0.00
Central venous catheter-related bloodstream infection	0.16	0.00	0.00
In-hospital fall with hip fracture	0.09	0.05	0.00
Perioperative hemorrhage or hematoma	2.61	1.96	2.30
Postoperative acute kidney injury requiring dialysis	0.89	0.60	0.00
Postoperative respiratory failure	4.54	2.42	7.97
Perioperative pulmonary embolism or deep vein thrombosis	2.97	4.22	0.00
Postoperative sepsis	3.55	3.33	8.97
Postoperative wound dehiscence (rupture along incision)	0.82	0.34	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.00	0.74	0.00

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

The patient safety indicator measure for perioperative hemorrhage or hematoma shows a higher reported rate than Veterans Integrated Service Network (VISN) 17, and two measures (postoperative respiratory failure and postoperative sepsis) show a higher reported rate than VISN 17 and VHA.

A single patient developed perioperative hemorrhage or hematoma following colon surgery. A surgical work group reviewed this case and determined that care was appropriate.

Two patients had postoperative respiratory failure. Of these, one also developed sepsis and acute renal injury. The VISN 17 lead surgeon reviewed the case, assessed the provider's surgical

[28] According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is one which was caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care. (The website was accessed on March 6, 2019.)

outcomes, and did not identify a problem with the provider's practice. However, an internal facility review determined that another course of treatment would have been more beneficial to the patient, and education was provided to surgery providers. The second patient had recently completed chemotherapy for lung cancer prior to surgery for a ruptured ulcer. The surgeon had documented surgical interventions prior to surgery for this high-risk patient, and the care was deemed to be appropriate.

Two patients had postoperative sepsis. As mentioned above, one patient also developed respiratory failure during the same hospitalization and a perioperative hematoma during an earlier hospitalization. The VISN 17 lead surgeon and the facility reviewed this case and implemented required actions, including a surgical workgroup review of postoperative occurrences and returns to surgery. The second patient had positive blood cultures after colon surgery, was treated with antibiotics, and discharged home.

The OIG team noted that the number of occurrences did not trigger the facility to conduct a more in-depth review of all of the cases for tracking, trending, and identifying opportunities for improvement. However, the facility requested a VISN review and conducted its own internal review regarding the surgical outcomes for one provider.

The OIG also reviewed patient safety indicator data for FY 2018, quarter 4 (the most recent data) and the previous four quarters to identify any potential trends that may impact patient safety or increase the risk for patient harm. It is important to note that although the data are collected and reported by quarter, each set of quarterly data represents potential complications or patient safety events over an eight-quarter or two-year period. Further, it is possible for a facility measure to exceed the VHA rate due to a single incident and for that measure to vary above or below the VHA rate over time due to differences in the number of patients treated. Figure 5 illustrates the timeframes covered by the data reviewed.

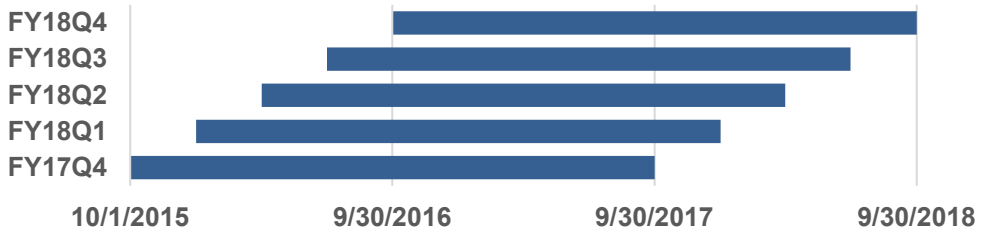

Figure 5. *Associated Timeframes for Quarterly Patient Safety Indicator Data*
Source: VA OIG
FY18Q4 = fiscal year 2018, quarter 4
FY18Q3 = fiscal year 2018, quarter 3
FY18Q2 = fiscal year 2018, quarter 2
FY18Q1 = fiscal year 2018, quarter 1
FY17Q4 = fiscal year 2017, quarter 4

Table 8 summarizes patient safety indicator data for FY 2017, quarter 4 (FY17Q4) through FY 2018, quarter 4 (FY18Q4), which includes potential complications from October 1, 2015, through September 30, 2018.

Table 8. Patient Safety Indicator Data Trending (October 1, 2015, through September 30, 2018)

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Pressure ulcer	VHA	0.60	0.88	—[29]	0.76	0.74
	Facility	0.00	0.45	—	0.00	0.00
Death among surgical inpatients with serious treatable conditions	VHA	100.97	118.96	113.92	114.89	113.42
	Facility	51.28	54.05	41.67	0.00	0.00
Iatrogenic pneumothorax	VHA	0.19	0.19	0.17	0.15	0.17
	Facility	0.00	0.00	0.00	0.00	0.00
Central venous catheter-related bloodstream infection	VHA	0.15	0.14	0.15	0.16	0.16
	Facility	0.00	0.00	0.00	0.00	0.00
In-hospital fall with hip fracture	VHA	0.08	0.09	0.08	0.09	0.09
	Facility	0.00	0.00	0.00	0.00	0.00
Perioperative hemorrhage or hematoma	VHA	1.94	2.58	2.62	2.59	2.61
	Facility	2.63	2.48	3.35	3.79	2.30
Postoperative acute kidney injury requiring dialysis	VHA	0.88	0.80	0.65	0.96	0.89
	Facility	0.00	0.00	0.00	0.00	0.00
Postoperative respiratory failure	VHA	5.55	5.34	5.11	4.88	4.54
	Facility	4.33	4.08	8.36	6.41	7.97
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.29	3.26	3.09	3.05	2.97
	Facility	7.61	7.17	6.44	5.49	0.00
Postoperative sepsis	VHA	4.00	3.96	3.72	3.70	3.55
	Facility	6.67	6.36	8.88	10.38	8.97
Postoperative wound dehiscence (rupture along incision)	VHA	0.52	1.04	1.00	0.93	0.82
	Facility	0.00	0.00	0.00	0.00	0.00
Unrecognized abdominopelvic accidental puncture or laceration	VHA	0.53	1.21	1.02	1.07	1.00
	Facility	0.00	0.00	0.00	0.00	0.00

Source: VHA Support Service Center

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

[29] According to VHA's Inpatient Evaluation Center, pressure ulcer data are not available for the timeframe of April 1, 2016, through March 31, 2018, due to an issue with patient transfer data.

Two measures (perioperative hemorrhage or hematoma and perioperative pulmonary embolism or deep vein thrombosis) have trended near or above the VHA average until most recently when both measures improved to below the VHA rate. The facility's perioperative hemorrhage or hematoma rates were ascribed to two patients admitted in April 2016 and April 2017, respectively. There have been no newly reported instances of perioperative hemorrhage or hematoma since that time. The facility's perioperative pulmonary embolism or deep vein thrombosis rates were attributed to six patients admitted from October 2015 through July 2016. The reported rate improved over time as patients' admission dates fell outside the quarterly data timeframe coverage. There have been no newly reported instances of perioperative pulmonary embolism or deep vein thrombosis since that time. No trends were observed for either measures.

Two additional measures (postoperative respiratory failure and postoperative sepsis) show an apparent recent uptrend in reported rates. The facility's postoperative respiratory failure rate was below the VHA rate until the second quarter of FY 2018 when a patient who was admitted in December 2017 developed sepsis and acute renal injury (discussed above). There have been no newly reported instances of postoperative respiratory failure since that time. The facility's postoperative sepsis rate has exceeded the VHA rate since the fourth quarter of FY 2017; however, this was due to one patient who experienced postoperative sepsis and was readmitted for sepsis and acute renal injury. No trends were observed for either measures.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[30]

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 6 describes the distribution of facilities by star rating.[31] As of June 30, 2018, the facility was rated as "4-star" for overall quality.

[30] 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=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

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

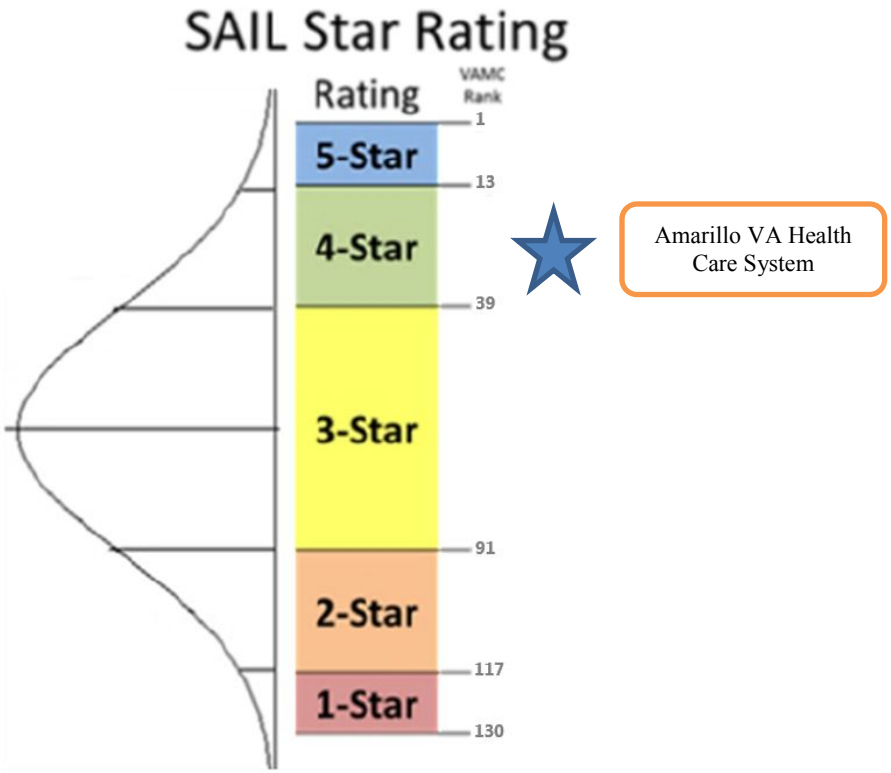

Figure 6. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed December 17, 2018)

Figure 7 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of mental health (MH) continuity (of) care, MH population coverage, and call responsiveness). Metrics that need improvement are denoted in orange and red (for example, complications, health care (HC) associated infections, and capacity).[32]

[32] For information on the acronyms in the SAIL metrics, please see Appendix D.

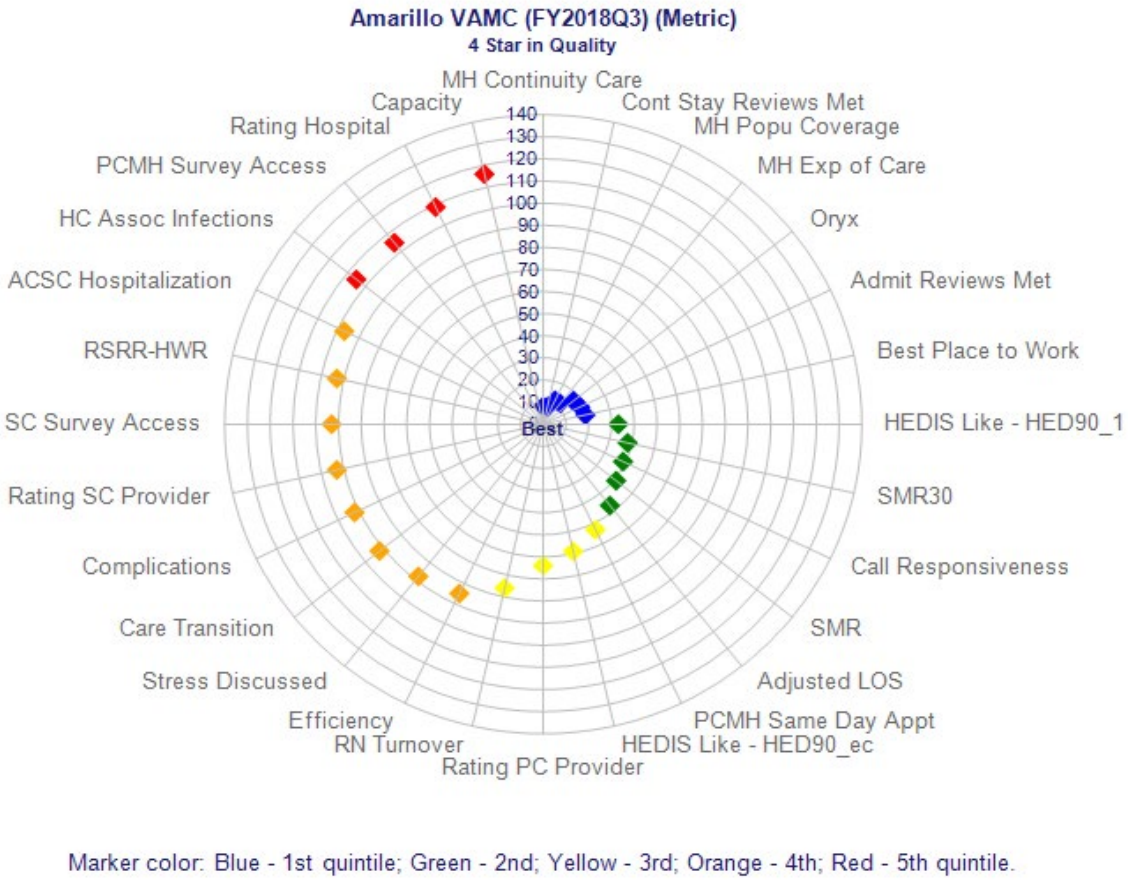

Figure 7. *Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[33] The SAIL CLC provides a single resource to review quality measures and health inspection results. It

[33] According to Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

includes star ratings for an unannounced survey, staffing, quality, and overall results.[34] Table 9 summarizes the rating results for the facility's CLC as of September 30, 2018. Although the facility has an overall "4-star" rating, its rating for quality is only a "2-star."

Table 9. Facility CLC Star Ratings (as of September 30, 2018)

Domain	Star Rating
Unannounced Survey	★★★
Staffing	★★★★★
Quality	★★
Overall	★★★★

Source: VHA Support Service Center

In exploring the reasons for the "2-star" quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 8 illustrates the facility's CLC quality rankings and performance compared with other VA CLCs as of September 30, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of high risk pressure ulcer (PU)–long stay (LS), urinary tract infection (UTI) (LS), and ability to move independently worsened (LS)). Metrics that need improvement and were likely the reasons why the facility had a "2-star" for quality are denoted in orange and red (for example, catheter in bladder (LS), newly received antipsychotic medications (Meds)–short stay (SS), and falls with major injury (LS)).[35]

[34] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

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

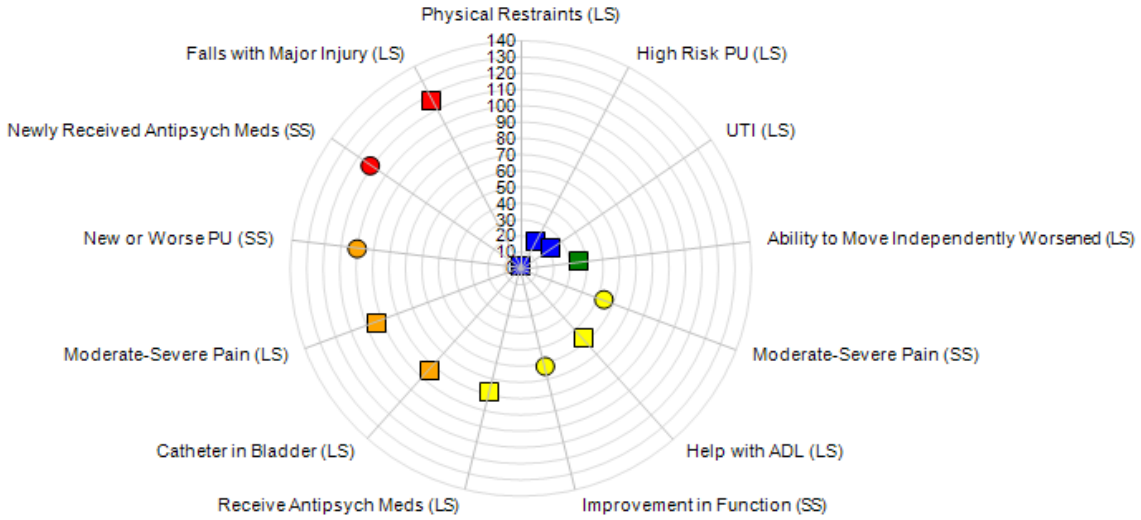

Figure 8. *Facility CLC Quality Measure Rankings (as of September 30, 2018)*
LS = Long-Stay Measure SS = Short-Stay Measure
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with three of the four positions permanently assigned for over three years prior to the OIG's on-site visit. Selected survey scores related to employee satisfaction with the facility executive leaders were generally better than VHA averages. Patient experience survey data also showed that satisfaction scores were above VHA averages. The facility leaders seemed actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The executive team 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). The OIG's review of the facility's accreditation findings, sentinel events, disclosures, and patient safety indicator data did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility, about selected SAIL and CLC metrics but should continue to take actions to sustain and improve performance of measures contributing to the SAIL "4-star" and CLC "2-star" quality ratings.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[36] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[37] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[38]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[39] utilization management (UM) reviews,[40] patient safety incident reporting with related root cause analyses,[41] and cardiopulmonary resuscitation (CPR) episode reviews.[42]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[43]

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[36] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 and has not been recertified.)

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

[38] VHA Directive 1026.

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

[40] According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria."

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

[42] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

[43] VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[44]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[45]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[46]

The OIG team interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[47]

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

[44] VHA Directive 1117(1).

[45] VHA Handbook 1050.01.

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

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

  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[48]
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[49]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

Quality, Safety, Value Conclusion

The OIG team found there was general compliance with requirements for protected peer reviews and patient safety. However, the team identified concerns with the lack of participation in

[48] VHA Directive 1190.

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

interdisciplinary reviews of UM data and incomplete analysis and trending of resuscitation episodes that warranted recommendations for improvement.

Specifically, VHA requires interdisciplinary review of UM data. This process must include, but is not limited to, participation by representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue-utilization review.[50] From January 2018 through November 2018, the QSV Board, the facility group that reviews UM data, lacked representation from social work and the chief business office revenue-utilization review. As a result, the QSV Board performed reviews and analyses of UM data without the perspectives of key social work and utilization review colleagues. Facility managers stated they were unaware of the requirements for the interdisciplinary review of UM data until November 2018, at which time a UM subcommittee was chartered. The first UM subcommittee meeting in December 2018 included all required representatives as members.

Recommendation 1

1. The chief of staff makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors the representatives' compliance.

Facility concurred.

Target date for completion: November 2019

Facility response: Utilization Management Sub-committee revised the charter to include the mandated roles per the Directive. Attendance will be reviewed monthly to ensure the interdisciplinary team required by Directive are present. This measure will be monitored until the mandated roles attend the Utilization Management Sub-committee 90% of the time or greater for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

VHA also requires that the facility establish a committee for reviewing each resuscitation episode under the facility's responsibility and that each review includes elements such as identification of errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, and clinical issues or patient care issues, and delays in initiating CPR or resuscitation.[51] The OIG team found no evidence that the Cardio Resuscitation Committee reviewed individual resuscitative episodes. This resulted in inadequate analysis of resuscitation episodes, trending, and missed opportunities for improvement, which may impact patient

[50] VHA Directive 1117(1).
[51] VHA Directive 1177.

safety.[52] Requirements were known to facility leaders, but staff stated that a former clinical leader conducted the reviews and did not discuss information about individual episodes at committee meetings.

Recommendation 2

2. The chief of staff ensures the Cardio Resuscitation Committee reviews each resuscitative episode for which the facility is responsible and monitors the committee's compliance.

Facility concurred.

Target date for completion: September 2019

Facility Response: A new trending spreadsheet will be created to include the monitoring of identification of errors or deficiencies in technique or procedures; lack of availability or malfunction of equipment; clinical or patient care issues; and delays in initiating CPR or resuscitation. This spreadsheet will be analyzed and discussed at the Medical Emergency Response Committee (MERC). Meeting minutes will be monitored for inclusion of the Resuscitation Episode Reviews in the committee meetings. This measure will continue to be monitored until the resuscitation reviews are discussed and analyzed at 100% of the MERC meetings for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

[52] VHA Directive 1177.

Medical Staff Privileging

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

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the 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 their expiration.[54]

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

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

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

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

[54] VHA Handbook 1100.19.

[55] VHA Handbook 1100.19.

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

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

- Three solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[58]
- Ten LIPs hired within 18 months before the site visit,
- Twenty LIPs re-privileged within 12 months before the visit,
- One provider who underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[59]
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and timeframes clearly documented
  - Evaluation by another provider with similar training and privileges
  - Medical Staff Executive Committee consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

[58] The 18-month period was from July 15, 2017, through January 14, 2019. The 12-month review period covered January 15, 2018, through January 14, 2019. VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being less than three providers in the facility that are privileged in a particular specialty.

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

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

Medical Staff Privileging Conclusion

The OIG team found general compliance with the requirements for FPPE for cause. However, the OIG identified noncompliance with selected requirements for the privileging, FPPE, and OPPE processes that warranted recommendations for improvement.

Specifically, VHA requires that providers' privileges are granted for a period not to exceed two years. This is to ensure that privileges are renewed on a time-limited basis and verified periodically.[60] For 5 of 33 profiles reviewed, there was no documentation of the approved privileging period. As a result, providers may have delivered care without a specified period in which they could practice at the facility. Managers reported that the cover letters, which contain the privileging dates for the five profiles, were lost during the transition from the previous lead credentialer to the current credentialing staff. Managers cited a lack of attention to detail as the reason for noncompliance.

Recommendation 3

3. The chief of staff ensures that provider privileges contain a clearly delineated timeframe not to exceed two years and monitors compliance.

[60] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: August 2019

Facility Response: A process was put into place for every provider to receive a confirmation letter upon privileging/re-privileging indicating that their privileges will not exceed two years. The Assistant Chief, Quality, Safety, Value, or designee will complete a manual review of 100% of newly privileged and re-privileged providers' credentialing and privileging folders to ensure the confirmation letter is sent to the providers following the Medical Executive Board decisions to initiate/renew privileges. This measure will be monitored until the providers are sent confirmation letters limiting their privileges to two years following committee decision 90% of the time or greater for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

For FPPEs, VHA requires that criteria are defined prior to initiation of the evaluations using objective criteria accepted by the practitioner and recommended by the service chief and Executive Committee of the Medical Staff.[61] This includes the minimum required specialty criteria for the professional practice evaluation defined by VHA for four specialty provider types, including pathology and laboratory medicine.[62] This ensures that the FPPE process is clear to the provider before initiating the evaluation. VHA also requires that FPPEs be time-limited and that results of the FPPE be documented in the provider's profile and reported to the Executive Committee of the Medical Staff.[63] Time limitations help to ensure an efficient process by preventing undefined or indefinite evaluation of providers.

For 5 of 11 applicable profiles reviewed, the team found no documentation that FPPE criteria were defined prior to the initiation of the evaluations. This included a solo pathology provider whose FPPE, therefore, did not include the minimum required specialty criteria defined by VHA. Additionally, clinical managers did not initiate FPPEs for 2 of 11 LIPs or clearly delineate the timeframe for 4 of the 9 initiated FPPEs. Finally, the Medical Executive Board did not document its decision in meeting minutes to recommend continuing the privileges for four providers based on FPPE results. This resulted in providers delivering care without a thorough evaluation of their practice. Managers reported turnover in key leadership positions, competing priorities among credentialing staff, and an ineffective organizational alignment of the credentialing department as reasons for noncompliance.

[61] VHA Handbook 1100.19.

[62] VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

[63] VHA Handbook 1100.19.

Recommendation 4

4. The chief of staff makes certain that service chiefs establish and define focused professional practice evaluation criteria that include the minimum required specialty criteria, as applicable, prior to initiation of the evaluations and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: November 2019

Facility Response: Focused professional practice evaluation (FPPE) forms were revised to include the nationally mandated criteria for the specialists required (GI, Lab and Pathology, and Nuclear Medicine). The Assistant Chief, Quality, Safety, Value, or designee will complete a manual review of use of the new FPPE form for inclusion of the mandated criteria for 100% of the new providers privileged under the designated specialties until compliance of 90% is achieved for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

Recommendation 5

5. The chief of staff confirms that service chiefs initiate and complete focused professional practice evaluations that include clearly delineated timeframes and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: November 2019

Facility Response: Focused professional practice evaluation (FPPE) forms were revised to include documentation that providers receive criteria and timeframes at the time FPPE is initiated. The Assistant Chief, Quality, Safety, Value, or designee will complete a manual review of 100% of newly privileged providers for use of the revised FPPE forms ensure that the criteria and time-frame are included and communicated to the provider at the time the FPPE is initiated until compliance of 90% is achieved for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

Recommendation 6

6. The chief of staff ensures that the Medical Executive Board documents consideration of focused professional practice evaluation results in its decision to recommend approval of requested privileges and monitors the Medical Executive Board's compliance.

Facility concurred.

Target date for completion: November 2019

Facility Response: Focused professional practice evaluation (FPPE) forms were revised to include the decision of the Medical Executive Board (MEB) and signed by the Chair of MEB. Additionally, education was provided to Credentialing and Privileging staff to include the decision of the committee regarding all FPPEs in the meeting minutes. The Chief of Staff will review 100% of MEB Meeting minutes to ensure compliance with documenting the decision of the committee at the end of a FPPE until compliance is 90% for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

For OPPEs, VHA requires that service chiefs consider service-specific data utilizing defined criteria when recommending the continuation of an LIP's privileges to the Medical Executive Board. In turn, the Medical Executive Board is required to document the review and approval of the provider's clinical competence when renewing privileges. OPPE data are maintained as part of the practitioner's profile and may include periodic chart reviews, direct observation, monitoring of diagnostic and treatment techniques, or clinical discussions.[64]

Of the 22 applicable provider profiles in which an OPPE was used to support the renewal of a practitioner's privileges, the OIG found that 14 had no evidence of service-specific criteria and 19 did not contain evidence of complete data collection. In addition, the Medical Executive Board meeting minutes did not document discussion of OPPE data for 11 providers. As a result, providers delivered care with insufficient data to evaluate their practice and without confirmation of the quality of care they provided. The chief of staff stated that the lack of service chiefs' accountability due to the current credentialing organizational structure was the reason for noncompliance.

Recommendation 7

7. The chief of staff confirms that service chiefs include the review of service-specific data for ongoing professional practice evaluations and monitors service chiefs' compliance.

[64] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: December 2019

Facility Response: Ongoing professional practice evaluations (OPPE) forms were revised to include service/specialty specific criteria. Service Chiefs and the Medical Executive Board will manually review 100% of OPPEs for inclusion of service/specialty specific criteria. This will be monitored until compliance is 90% for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

Recommendation 8

8. The chief of staff makes certain that service chiefs consistently collect and review ongoing professional practice evaluation data and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: December 2019

Facility Response: Monitoring of ongoing professional practice evaluations (OPPE) has been added as a standing agenda item on all Medical Executive Board meetings to bring awareness of service chiefs to ensure completion (data collection and review) of accurate OPPEs. Additionally, the Chief of Staff will evaluate service chiefs on their compliance with the OPPE process on their Annual Executive Career Field (ECF) evaluation. OPPE completion will be monitored until 90% compliance is reached for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

Recommendation 9

9. The chief of staff ensures that the Medical Executive Board documents its decision to recommend continuing privileges based on ongoing professional practice evaluation results and monitors the board's compliance.

Facility concurred.

Target date for completion: November 2019

Facility Response: Ongoing professional practice evaluation (OPPE) forms were revised to include the decision of the Medical Executive Board (MEB) and signed by the Chair of MEB. Additionally, education was provided to Credentialing and Privileging staff to include the decision of the committee regarding the continuation of privileges based in part on the results of the provider's OPPE. Meeting minutes will be reviewed by the Chief of Staff to ensure compliance with documenting the decision of the committee at the time of recredentialing that the decision was made with consideration of the provider's OPPE until compliance is 90% for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional, but should also promote healing.[65]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[66]

VHA requires its facilities to have the "capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[67]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[68] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,

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

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

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

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

Occupational Safety and Health Administration,[69] and National Fire Protection Association standards.[70] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[71]

In all, the OIG team inspected 12 areas—two medical/surgical units (3N and 3S), intensive care unit, two community living center units (A and B), post-anesthesia care unit, same day surgery, emergency department, women's health clinic, geriatric clinic, specialty clinic, and primary care clinic. The team also inspected the Clovis VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit[72]
  - Mental health environment of care rounds
  - Nursing station security

[69] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's Mission is to assume safe and healthy working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html. (This website was accessed on June 28, 2018.)

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

[71] TJC. Environment of Care standard EC.02.05.07.

[72] The facility did not have an inpatient mental health unit.

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

Environment of Care Conclusion

Privacy measures were in place at the parent facility and the representative community based outpatient clinic generally met the performance indicators evaluated. The OIG team did not note any issues with the availability of medical equipment and supplies. However, the team found expired and unlabeled medications, clean and soiled supplies and equipment stored together, and a deficiency with emergency power testing, which warranted recommendations for improvement.

Specifically, TJC requires that all expired, damaged, and/or contaminated medications be stored separately from medications available for administration.[73] The OIG team found expired multi-dose insulin vials stored with in-use vials on one unit and an open, undated multi-dose insulin vial on another unit.[74] This resulted in the lack of assurance of safe medication administration. Facility managers stated that staff were aware of proper medication storage requirements but did not follow facility procedures.

Recommendation 10

10. The associate director ensures staff store expired medications separately from medications available for administration and label medication vials with an expiration date upon opening and monitors staff's compliance.

[73] TJC. Medication Management standard MM.03.01.01.

[74] Medical-surgical 3S unit and 2nd floor CLC (B) unit.

Facility concurred.

Target date for completion: December 2019

Facility Response: A process was put into place on ICU, Medical/Surgical unit, Community Living Center, and PACT for staff, nurse managers, and/or assistant nurse managers to regularly round in their areas to physically assess for expired or unsecured medications or multidose vials without expirations clearly labeled. Each unit will track their assessments until compliance of 90% or greater is achieved for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council until successful maintenance of compliance.

TJC also requires hospitals to store dirty and used equipment separately from clean equipment and sterile supplies to minimize the transmission of infections.[75] The OIG found that dirty equipment was not separated from clean equipment and/or supplies in 3 of the 12 areas inspected.[76] This resulted in a lack of assurance of a clean and safe patient care environment that minimizes the spread of infection. Facility managers attributed the improper use of storage and nonstorage areas throughout the facility was due to staff's inattention to detail.

Recommendation 11

11. The associate director ensures that staff store clean and dirty medical equipment and supplies separately and monitors compliance.

Facility concurred.

Target date for completion: December 2019

Facility Response: In the ICU and Medical/Surgical units, the nurse manager/assistant nurse manager have implemented assigned duties to include evaluation of the clean and soiled utility rooms to ensure there is no co-mingling of clean and soiled supplies. This evaluation started on Monday February 11, 2019 and has a frequency of 3 days per week on ICU and the Medical/Surgical unit. In the PACU/Day Surgery area, the manager has designated a clean area where clean packs can be made for patients. The PACU/Day Surgery Nurse Manager/Assistant Nurse Manager round on the designated area weekly. Review of all three units will be monitored until 90% compliance is achieved for 6 consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council until successful maintenance of compliance.

[75] TJC. Infection Prevention and Control standard IC.02.01.01.

[76] Medical-surgical 3S unit, intensive care unit, and post-anesthesia care unit.

The National Fire Protection Association requires facilities to test the ability of its emergency power supply system to deliver the required power to emergency power outlets.[77] The OIG did not find evidence that all emergency power outlets were tested while on the emergency power supply system. Testing increases the likelihood of detecting problems and reduces the risk of losing critical emergency power when needed. Facility managers attributed the noncompliance to the lack of a formal process for testing emergency outlets and relying solely on staff to report problems as they occur.[78]

Recommendation 12

12. The associate director ensures that managers test all emergency power outlets and monitors managers' compliance.

Facility concurred.

Target date for completion: August 2019

Facility Response: All emergency electrical outlets were tested as required. Additionally, emergency electrical outlets were placed on a preventative maintenance schedule for annual testing with reminders in order to ensure all are tested on a regular basis. This is compliant until April 2020. The facility will provide testing information upon OIG's request.

[77] NFPA 110. *Standard for Emergency and Standby Power Systems*, 2016 edition.

[78] All inpatient and outpatient care areas.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[79] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[80]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[81]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the two prior completed quarters;[82] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee's review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments[83]
- Requirements for controlled substances inspectors

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

[80] 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.

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

[82] The two quarters were from July 1, 2018, through December 31, 2018.

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

  - No conflicts of interest
  - Appointed in writing by the director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required annual competency assessment
- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction[84]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of 72-hour inventories of the main vault
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[85]

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

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

Medication Management Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

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

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[86] MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[87]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leaders.[88] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[89]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system (CPRS).[90] Those who screen positive must have access to appropriate MST-related care.[91] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[92]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[93] All mental health and primary care providers must complete MST mandatory

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

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

[88] VHA Directive 1115.

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

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

[91]VHA Directive 1115.

[92] VHA Handbook 1160.01.

[93] VHA Directive 1115.

training; for those hired after July 1,2012, this training must be completed no later than 90 days after assuming their position.[94]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents, staff training records, and interviewed key employees. The team also reviewed the electronic health records of 50 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

Mental Health Conclusion

Generally, the OIG team found the facility achieved many of the performance indicators in complying with requirements, including the designation of an MST coordinator, tracking of MST-related data, referral for related care, and the provision of clinical care. The team noted noncompliance with MST coordinator responsibilities and completion of MST mandatory training by providers that warranted recommendations for improvement.

VHA requires that the facility MST coordinator establishes and monitors MST-related staff training and communicates MST-related issues, services, and initiatives with facility leaders.[95] The OIG team determined that the MST coordinator had no process in place for monitoring the

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

[95] VHA Directive 1115.

training or communicating the information to leaders. This may hinder the MST coordinator's efforts to enhance staff training and leaders' ability to identify and address improvement opportunities. The MST coordinator was unaware of the requirements and had been reporting solely to the Women Veterans' Health Committee.

Recommendation 13

13. The chief of staff ensures the military sexual trauma coordinator tracks military sexual trauma-related staff training and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: November 2019

Facility Response: AVAHCS (Amarillo VA Health Care System) Education department completed a full review and ensured that required MST training curricula, as specified by EES Mandatory Training requirements for Mental Health, Social Worker, Provider and Primary Care Nursing, was added. When new staff in one of these categories arrives at AVAHCS, they are automatically assigned the required curricula for their position, and the MST training is automatically due within 90 days. Assignment and timely completion of the required MST training will be tracked by the MST Coordinator and reported as a standing agenda item at the Military Sexual Trauma Committee. Committee minutes will be reviewed for inclusion of the tracking of required MST training until 100% compliance is reached and maintained for six consecutive months. This will be reported through the Continuous Readiness Meeting on a quarterly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

Recommendation 14

14. The chief of staff ensures the military sexual trauma coordinator communicates the status of military sexual trauma-related information to leaders and monitors the coordinator's compliance.

Facility concurred.

Target date for completion: November 2019

Facility Response: A new committee was chartered for Military Sexual Trauma. This committee reports via the governance structure to the Medical Executive Board and then to Leadership at the Executive Health Care Council. Meeting minutes of the Military Sexual Trauma committee and MEB will be reviewed monthly to ensure inclusion of MST-related information. This will be monitored by the MST Coordinator until 100% compliance has been obtained for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council until successful maintenance of compliance.

VHA requires that all mental health and primary care providers complete the MST mandatory training requirement no later than 90 days after entering their position.[96] Of the 20 training records reviewed, three providers had not completed the training and one provider did not complete the training within 90 days of the date of hire. This could potentially result in clinicians providing counseling, care, and services without the required MST training.[97] Facility managers cited ineffective controls and oversight to ensure timely training as the reason for noncompliance.

Recommendation 15

15. The chief of staff ensures providers complete military sexual trauma mandatory training within the required timeframe and monitors providers' compliance.

Facility concurred.

Target date for completion: November 2019

Facility Response: A new process was developed so that when new providers arrive at AVAHCS, they are automatically assigned the required curricula for their position, and the MST training is automatically due within 90 days. Assignment and timely completion of the required MST training for new providers will be monitored by the MST Coordinator until 90% compliance is reached and maintained for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

[96] VHA Directive 1115.01.

[97] VHA Directive 1115.01.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder"[98] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[99]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[100]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[101] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[102] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[103] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[104] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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

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

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

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

[102] TJC. Provision of Care, Treatment, and Services standard PC 02.03.01.

[103] VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

[104] TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[105]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 42 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[106] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

The OIG found facility compliance with providers justifying the reason for medication initiation, reconciling patient's medications, and documenting adverse drug reactions. However, the OIG identified that providers did not provide adequate patient and/or caregiver education specific to the newly prescribed antidepressant drug, which warranted a recommendation for improvement.

Specifically, TJC requires that clinicians educate patients and families about safe and effective use of medications.[107] The OIG estimated that clinicians provided this education to 71 percent of the patients at the facility, based on electronic health records reviewed.[108] Providing medication education is critical to ensuring that patients or their caregivers have the information they need to manage their health at home. Facility managers were aware of the requirements and cited competing priorities, excessive documentation requirements, and limited administrative time as reasons for noncompliance.

[105] VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

[106] The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

[107] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

[108] The OIG is 95 percent confident that the true compliance rate is somewhere between 57.1 and 84.5 percent, which is statistically significantly below the 90 percent benchmark.

Recommendation 16

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

Facility concurred.

Target date for completion: November 2019

Facility Response: A new template for antidepressant use was created to include specific education documentation, including safe and effective use of the newly prescribed antidepressant. Additionally, provider education was presented regarding appropriate use of antidepressants in the geriatric population. The Chief, Quality, Safety, Value or designee will monitor 100% of all newly prescribed antidepressants in the review list for patient/caregiver education about the safe and effective use of the newly prescribed antidepressant. This will continue to be assessed until 90% compliance is achieved for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

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

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[109] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[110] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[111] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[112]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)" to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[113]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[114]

VHA has established timeframes for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

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

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

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

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

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

[114] VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[115]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 18 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

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

Women's Health Conclusion

Overall, the OIG determined the facility had attained many performance indicators, including those related to requirements for a designated women veterans program manager and clinical champion, clinical oversight of the women's health program, and follow-up care when indicated. The OIG noted noncompliance with the Women Veterans Health Committee membership, tracking data related to cervical cancer screenings, and communicating results to patients within the required timeframe, each warranting recommendations for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women's health medical director;

[115] VHA Directive 1330.01(2).

"representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, emergency department, radiology, laboratory, quality management, business office/non-VA medical care; and a member from executive leadership."[116] From October 2017 through December 2018, the committee lacked representation from mental health, medical and/or surgical subspecialties, gynecology, pharmacy, the emergency department, radiology, laboratory, business office/non-VA medical care, and the executive leadership team. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. Program managers expressed a lack of support from the VISN and previous facility leaders, as well as frequent turnover in the chief of staff position, as contributing factors for noncompliance.

Recommendation 17

17. The facility director confirms that the Women Veterans Health Committee includes required core members and monitors the committee's compliance.

Facility concurred.

Target date for completion: December 2019

Facility Response: The Women Veteran Committee (WVC) charter was revised to include the required core members per Directive. The Assistant Chief, Quality, Safety, Value, or designee will review committee meeting minutes for inclusion/attendance of the required core members. This will be monitored until 90% compliance is achieved for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

According to VHA, each facility must have a process to track data, "including notification of patients who are due for screening, tracking of completion of screening, results reporting, and follow-up care" related to cervical cancer screenings.[117] The OIG found that the facility did not have a systematic process for tracking results reporting and follow-up care data. One committee member acknowledged informally tracking follow-up care data; however, the results were not collated, analyzed, or reported in a manner consistent with quality improvement activities. Lack of a systematic process for tracking cervical cancer screening results reporting and follow-up care data may cause delays in addressing abnormal results and implementing appropriate follow-

[116] VHA Directive 1330.01(2).
[117] VHA Directive 1330.01(2).

up care.[118] Facility managers cited a lack of training, mentorship, and program support from VHA as reasons for noncompliance.

Recommendation 18

18. The chief of staff makes certain that program managers implement a process to track results reporting and follow-up care data for cervical cancer screenings and monitors program managers' compliance.

Facility concurred.

Target date for completion: December 2019

Facility Response: Additional columns were added to the data collection system to include: patient notification date/by whom after cervical cancer results and HPV results, as well as, follow-up column. In addition to columns, an area for capturing results received in a timely manner/patient results outside recommended time frame was added to the overall data collection system for review and analysis. This data will be presented with analysis to the Women Veterans Health Committee as a standing agenda item. The Assistant Chief, Quality, Safety, Value, or designee will review minutes for inclusion of this data. This will be monitored until 100% compliance is achieved for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

VHA also requires that the ordering provider notify patients of abnormal cervical cancer screening results within seven calendar days from the date the results are available.[119] The OIG determined that providers communicated abnormal results to patients in a timely manner in 83 percent of the electronic health records reviewed.[120] For the remaining cases, this lack of prompt communication may result in delays in follow-up care. Program managers reported several reasons for noncompliance, including ineffective oversight due to the women's health medical director transitioning to a clinical role, technical issues with the view alert notification system, and several providers delegating the notification task to other team members.

Recommendation 19

19. The chief of staff ensures that ordering providers communicate abnormal results to patients within the required timeframe and monitors providers' compliance.

[118] VHA Directive 1330.01(2).

[119] VHA Directive 1330.01(2).

[120] Confidence intervals are not included because the data represent every patient in the study population.

Facility concurred.

Target date for completion: December 2019

Facility Response: The March 2019 PACT included reminder training by the Women's Veterans Program Manager that provided education on reporting abnormal cervical cancer results and positive HPV results within recommended time frame (7 days). The Women's Diagnostic Coordinator will review 100% of abnormal cervical pathology results for timely notification as required. This will be monitored until 90% compliance is achieved for six consecutive months. This will be reported through the Continuous Readiness Meeting on a monthly basis through the governance structure to Leadership at the Executive Health Care Council and Medical Executive Board until successful maintenance of compliance.

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

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[121] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[122]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[123]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the ED or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[124]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.[125]

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

[122] VHA Directive 1101.05(2).

[123] VHA Directive 1101.05(2).

[124] TJC. Leadership standard LD.04.03.11.

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

VA emergency departments and UCCs must also be designed to promote a safe environment of care.[126] Managers must ensure medications are securely stored,[127] a psychiatric intervention room is available,[128] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[129]

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

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

[126] VHA Directive 1101.05(2).

[127] TJC. Medication Management standard MM.03.01.01.

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

[129] VHA Directive 1101.05(2).

  - Licensed independent mental health provider available as required for the facility's complexity level
  - Telephone message system during non-operational hours
  - Inpatient provider available for patients requiring admission
- Patient flow
  - EDIS tracking program
  - Emergency department patient flow evaluation
  - Diversion policy
  - Designated bed flow coordinator
- General safety
  - Directional signage to after-hours emergency care
  - Fast tracks[130]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
  - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

Generally, the facility achieved the performance indicators listed above. The OIG made no recommendations.

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

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Nineteen OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff, and associate director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• The Cardio Resuscitation Committee reviews each resuscitative episode for which the facility is responsible.	• Required representatives consistently participate in interdisciplinary reviews of UM data.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Service chiefs establish and define FPPE criteria that include the minimum required specialty criteria, as applicable, prior to initiation of the evaluations. • Service chiefs initiate and complete FPPEs that include clearly delineated timeframes. • Service chiefs include the review of service-specific data for OPPEs. • Service chiefs consistently collect and review OPPE data.	• Provider privileges contain a clearly delineated timeframe not to exceed two years. • The Medical Executive Board documents consideration of FPPE results in its decision to recommend approval of requested privileges. • The Medical Executive Board documents its decision to recommend continuing privileges based on OPPE results.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Community based outpatient clinic
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Locked inpatient mental health unit
	  ○ Mental health environment of care 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
		• Expired medications are stored separately from medications available for administration and medication vials are labeled with an expiration date upon opening.
		• Clean and dirty medical equipment and supplies are stored separately.
		• All emergency power outlets are tested.
			• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• None
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• Providers complete MST mandatory training within the required timeframe.	• The MST coordinator tracks MST-related staff training. • The MST coordinator communicates the status of MST-related information to leaders.
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• None	• Clinicians provide and document patient/caregiver education specific to the newly prescribed medications.
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data	• Ordering providers communicate abnormal results to patients within the required timeframe.	• The Women Veterans Health Committee includes core members. • A process is implemented for tracking results reporting and follow-up care data for cervical cancer screenings.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Communication of abnormal results to patients within required timeframe • Provision of follow-up care for abnormal cervical pathology results, if indicated		
High-Risk Processes: Operations and Management of Emergency Departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment	• None	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this medium complexity (2) affiliated[131] facility reporting to VISN 17.[132]

Table B.1. Facility Profile for Amarillo (504)
(October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[133]	Facility Data FY 2017[134]	Facility Data FY 2018[135]
Total medical care budget in dollars	$195,863,170	$206,674,999	$224,318,949
Number of:			
• Unique patients	25,190	24,063	24,450
• Outpatient visits	264,291	256,231	262,369
• Unique employees[136]	891	923	970
Type and number of operating beds:			
• Community living center	120	120	120
• Medicine	30	30	30
• Surgery	14	14	14
Average daily census:			
• Community living center	109	97	108
• Medicine	15	16	15
• Surgery	5	4	3

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.

[131] Associated with a medical residency program.

[132] The VHA medical centers are classified according to a facility complexity model; a designation of "2" indicates a facility with medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs.

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

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

[135] October 1, 2017, through September 30, 2018.

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

VA Outpatient Clinic Profiles[137]

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

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)[138]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[139] Provided	Diagnostic Services[140] Provided	Ancillary Services[141] Provided
Lubbock, TX	504BY	16,192	12,644	Cardiology Dermatology Gastroenterology Nephrology Rheumatology Poly-trauma Eye General surgery Podiatry	Laboratory & pathology Radiology	Pharmacy Social work Weight management Dental Nutrition

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

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

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

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

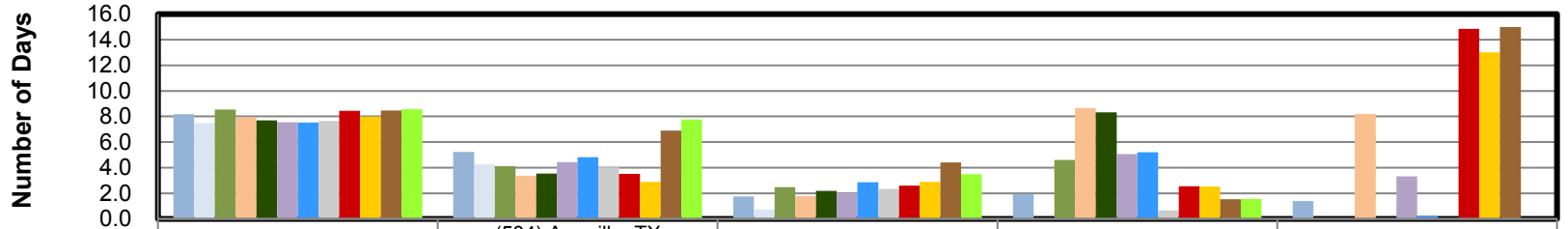
[141] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[139] Provided	Diagnostic Services[140] Provided	Ancillary Services[141] Provided
Clovis, NM	504BZ	3,512	3,837	n/a	n/a	Pharmacy Weight management Nutrition
Childress, TX	504GA	981	66	n/a	n/a	Pharmacy
Dalhart, TX	504HB	416	45	n/a	n/a	Pharmacy Weight management Nutrition

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[142]

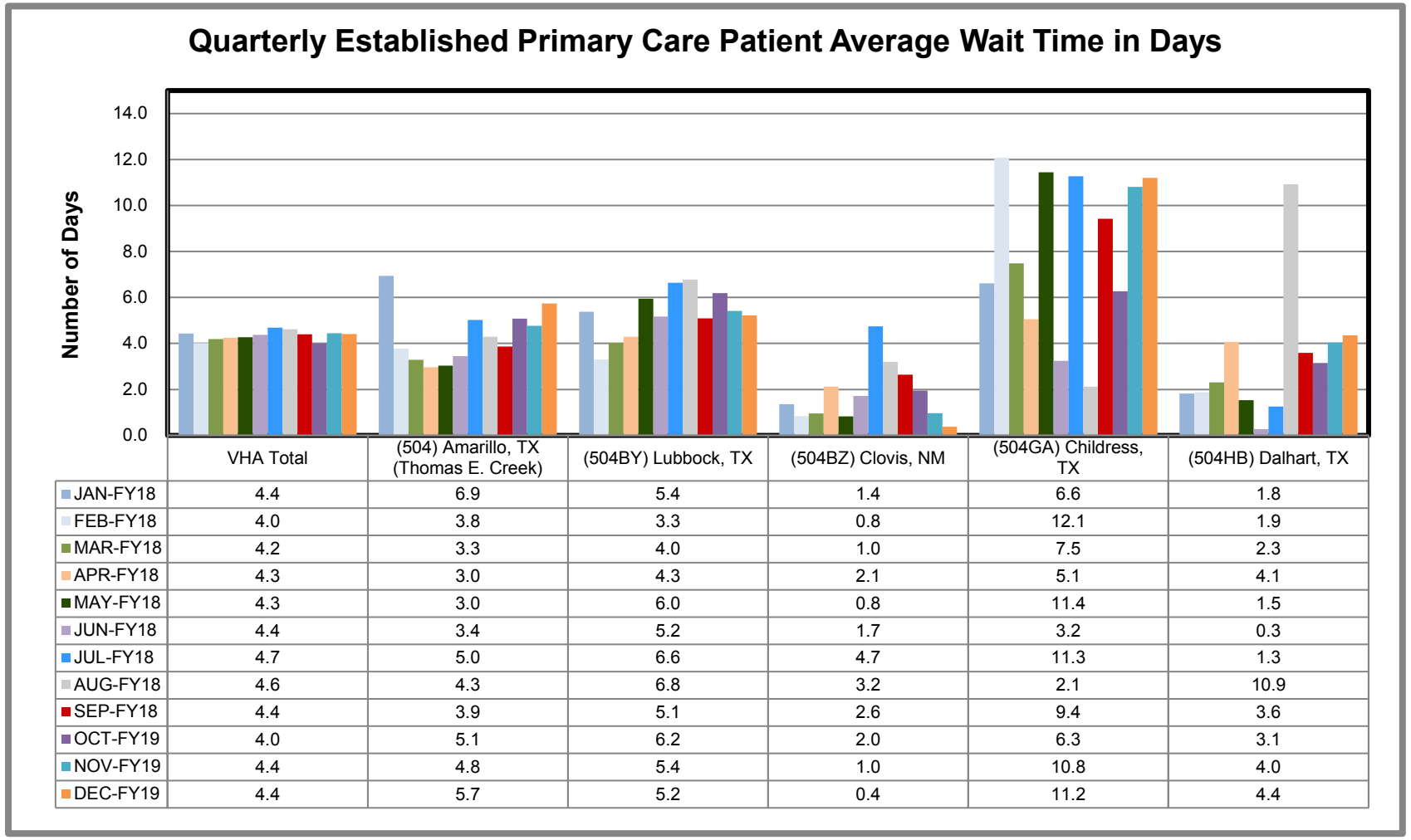
Quarterly New Primary Care Patient Average Wait Time in Days



	VHA Total	(504) Amarillo, TX (Thomas E. Creek)	(504BY) Lubbock, TX	(504BZ) Clovis, NM	(504GA) Childress, TX
JAN-FY18	8.2	5.2	1.7	2.0	1.4
FEB-FY18	7.5	4.3	0.7	0.0	n/a
MAR-FY18	8.6	4.1	2.5	4.6	0.0
APR-FY18	7.9	3.4	1.8	8.7	8.2
MAY-FY18	7.7	3.6	2.2	8.3	0.0
JUN-FY18	7.6	4.4	2.0	5.1	3.3
JUL-FY18	7.5	4.8	2.9	5.2	0.2
AUG-FY18	7.7	4.0	2.3	0.7	0.0
SEP-FY18	8.5	3.5	2.6	2.5	14.9
OCT-FY19	8.0	2.9	2.9	2.5	13.0
NOV-FY19	8.5	6.9	4.4	1.5	15.0
DEC-FY19	8.6	7.8	3.5	1.6	n/a

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Dalhart, TX (504HB), as no data were reported.
Data Definition: "The average number of calendar days between a new patient's primary care completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY15, this metric was calculated using the earliest possible create date." The absence of reported data are indicated by "n/a."

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



	VHA Total	(504) Amarillo, TX (Thomas E. Creek)	(504BY) Lubbock, TX	(504BZ) Clovis, NM	(504GA) Childress, TX	(504HB) Dalhart, TX
JAN-FY18	4.4	6.9	5.4	1.4	6.6	1.8
FEB-FY18	4.0	3.8	3.3	0.8	12.1	1.9
MAR-FY18	4.2	3.3	4.0	1.0	7.5	2.3
APR-FY18	4.3	3.0	4.3	2.1	5.1	4.1
MAY-FY18	4.3	3.0	6.0	0.8	11.4	1.5
JUN-FY18	4.4	3.4	5.2	1.7	3.2	0.3
JUL-FY18	4.7	5.0	6.6	4.7	11.3	1.3
AUG-FY18	4.6	4.3	6.8	3.2	2.1	10.9
SEP-FY18	4.4	3.9	5.1	2.6	9.4	3.6
OCT-FY19	4.0	5.1	6.2	2.0	6.3	3.1
NOV-FY19	4.4	4.8	5.4	1.0	10.8	4.0
DEC-FY19	4.4	5.7	5.2	0.4	11.2	4.4

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
Data Definition: "The average number of calendar days between an established patient's primary care completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[143]

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

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

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

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

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

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[144]

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

[144] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 20, 2019

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

Subj: Comprehensive Healthcare Inspection of the Amarillo VA Health Care System, TX

To: Director, Los Angeles Office of Healthcare Inspections (54CH01)

Thank you for the opportunity to provide an initial response for the OIG CHIP Draft Report for the Amarillo VA.

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

(Original signed by:)

Wendell Jones, MD
Chief Medical Officer

for

Jeff Milligan
Network Director, VA Heart of Texas Health Care Network
VISN 17

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

Appendix G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 20, 2019

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

Subj: Comprehensive Healthcare Inspection of the Amarillo VA Health Care System, TX

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

1. Thank you for conducting the Comprehensive Healthcare Inspection (OIG) review during the week of January 14, 2019 at the Amarillo VA Health Care System.

2. The recommendations have been reviewed. Amarillo concurs with all recommendations.

3. A plan of action for each of the nineteen recommendations is attached. The nineteen plans of action have been carefully analyzed and will be implemented and monitored through satisfactory completion.

4. I have reviewed the document and concurs with the response as submitted.

(Original signed by:)

Michael L. Kiefer
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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