



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

Office of Healthcare Inspections

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

February 5, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	West Texas VA Health Care System
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RRTP	residential rehabilitation treatment program
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

	Page
Report Overview	i
Purpose and Scope	1
Purpose	1
Scope.....	1
Methodology	2
Results and Recommendations	4
Leadership and Organizational Risks	4
Quality, Safety, and Value	14
Medication Management: Anticoagulation Therapy	16
Coordination of Care: Inter-Facility Transfers	19
Environment of Care.....	22
Mental Health Residential Rehabilitation Treatment Program	24
Post-Traumatic Stress Disorder Care	28
Appendixes	
A. Summary Table of Comprehensive Healthcare Inspection Program Review Findings.....	32
B. Facility Profile and VA Outpatient Clinic Profiles	36
C. VHA Policies Beyond Recertification Dates.....	38
D. Patient Aligned Care Team Compass Metrics	40
E. Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions.....	44
F. Relevant OIG Reports	46
G. VISN Director Comments	47
H. Facility Director Comments.....	48
I. OIG Contact and Staff Acknowledgments	49
J. Report Distribution	50
K. Endnotes	51

Report Overview

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

CHIP reviews are one element of the Office of Inspector General's (OIG) overall efforts to ensure that our nation's veterans receive high-quality and timely VA health care services. The reviews are performed approximately every 3 years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG's current areas of focus are:

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care
5. Environment of Care
6. High-Risk Processes
7. Long-Term Care¹

This review was conducted during an unannounced visit made during the week of June 19, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the West Texas VA Health Care System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Leadership Council having oversight for leadership groups such as the Employee Development Board, Medical Executive Board, and Quality Executive Board. The leaders are members of the Leadership Council through which they track, trend, and monitor quality of care and patient outcomes.

¹ The Community Nursing Home Oversight special focus area did not apply for the West Texas VA Health Care System because the facility only provided limited long-term care to patients for greater than 90 days through contracts.

All members of the executive leadership team are currently permanently assigned but have only been working together as a team since the Nurse Executive was assigned in June 2017. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted opportunities to improve patient satisfaction.

OIG recognizes that the 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 the Veterans Health Administration (VHA).² Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 1-star SAIL rating.

In the review of key care processes, OIG issued 11 recommendations that are attributable to the Chief of Staff and Associate Director. Of the six areas of clinical operations reviewed, OIG noted findings in four. These are briefly described below.

Medication Management. OIG found safe anticoagulation therapy management practices. However, OIG identified deficiencies in providing specific education to patients with newly prescribed anticoagulant medications and obtaining all required laboratory tests prior to initiating warfarin.

Coordination of Care. OIG noted the development and implementation of a patient transfer policy but identified deficiencies with documentation and communication of all required elements for patient transfers to accepting facilities.

Mental Health Residential Rehabilitation Treatment Program. OIG found compliance with the cleanliness of the Mental Health Residential Rehabilitation Treatment Program facility. However, OIG identified deficiencies in conducting and documenting monthly self-inspections and weekly contraband inspections, and ensuring all doors not considered as the main point of entry have audible alarms.

Post-Traumatic Stress Disorder Care. OIG noted the facility did not meet requirements with the performance indicators. OIG identified deficiencies in acceptable providers performing and documenting suicide risk assessments, offering further diagnostic evaluations, and completing diagnostic evaluations within 30 days for all patients with positive post-traumatic stress disorder screens. Additionally, OIG found a deficiency with documentation of resident supervision in the electronic health record not meeting VHA requirements.

² VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017:

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>.

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” ranking system to designate a facility’s performance in individual measures, domains, and overall quality.

Summary

In the review of key care processes, OIG issued 11 recommendations that are attributable to the Chief of Staff and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership 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 G and H, pages 47–48, and the responses within the body of the report for the full text of the Directors’ comments.) OIG considers recommendations 5, 6, 7, and 11 closed. OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

Purpose

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

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1). However, the Moderate Sedation and Community Nursing Home Oversight special focus areas did not apply for the West Texas VA Health Care System because the facility did not perform procedures using moderate sedation and provided limited long-term care for greater than 90 days through contracts. Thus, OIG focused on the remaining four areas of clinical operations and two additional programs with relevance to the facility—Mental Health Residential Rehabilitation Treatment Program and Post-Traumatic Stress Disorder Care.

**Figure 1. Fiscal Year 2017 Comprehensive Healthcare Inspection Program
Review of Health Care Operations and Services**



Source: VA OIG.

Additionally, OIG staff provide crime awareness briefings to increase facility employees’ understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to OIG.

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements³ related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;⁴ and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for May 13, 2014⁵ through June 19, 2017, the date when an unannounced week-long site visit commenced. Inspectors conducted the review in accordance with OIG standard operating procedures for CHIP reviews. On June 27, 2017, OIG presented crime awareness briefings to 105 of the facility’s 659 employees. These briefings covered procedures for reporting suspected criminal

³ Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.

⁴ OIG did not review VHA’s internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

⁵ This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

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

Results and Recommendations

Leadership and Organizational Risks

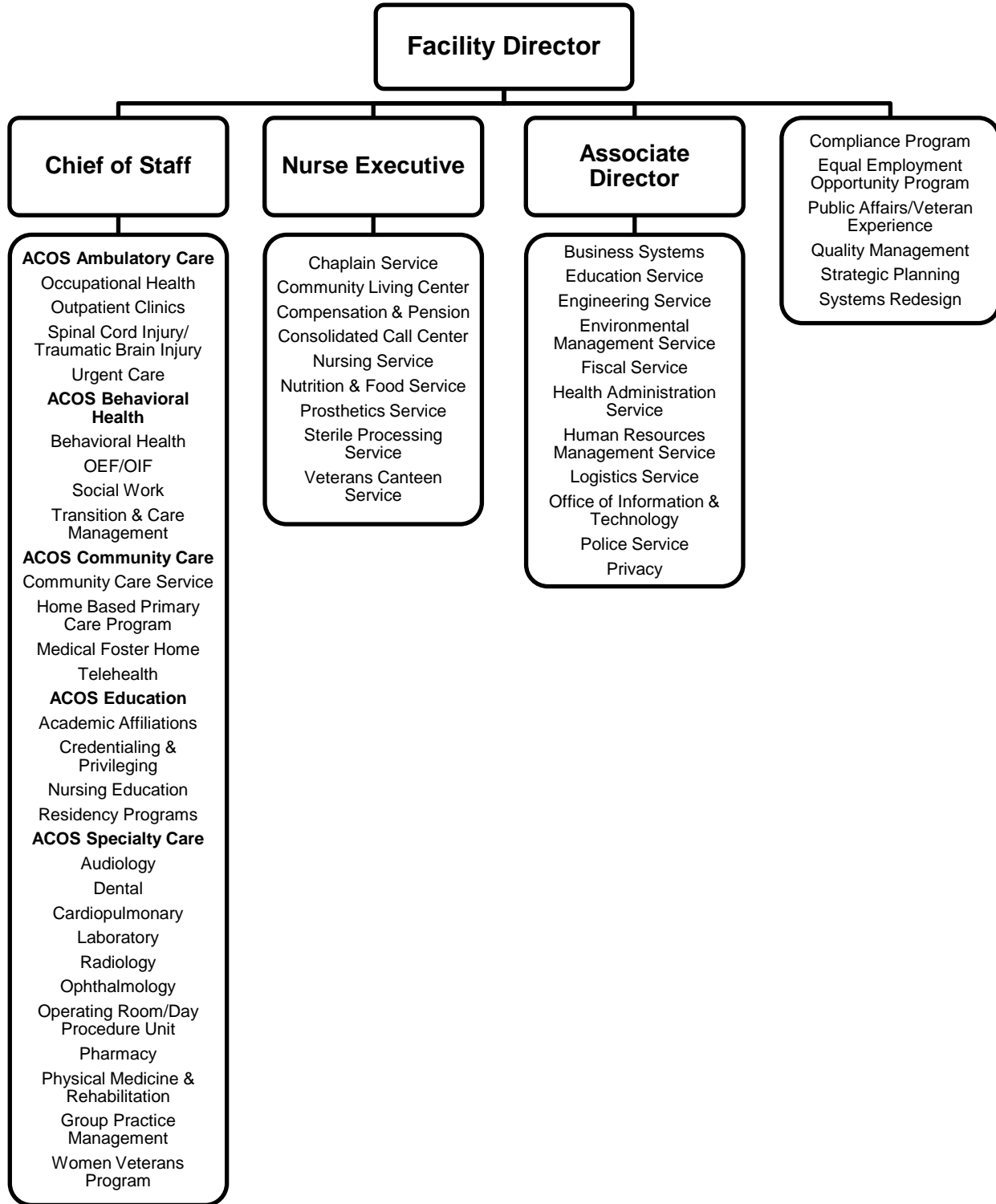
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and strengths were:

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

Executive Leadership Stability and Engagement. Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ between facilities. Figure 2 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 (Nurse Executive), and Associate Director. The Chief of Staff and Nurse Executive are responsible for overseeing patient care and service and program chiefs.

It is important to note that the Facility Director served as the Interim Director for 11 months before being permanently assigned in December 2016. The Nurse Executive position had been vacant for approximately 4 years before the most recent Interim was permanently assigned in June 2017. The Associate Director and the Chief of Staff were permanently assigned in July and September 2015, respectively. At the time of our site visit, none of the leadership team had been at the facility for more than 2 years, and all were in their current senior leadership positions for the first time in their VA career. Staff generally described the facility as a "revolving door" and a "stepping stone" among VA employees pursuing their first VA senior executive position. The current leaders are aware of this perception and commented that they are making an effort to be more transparent by consistently communicating the facility's strategic plan to staff and stakeholders. By doing so, the leaders hope that employees will focus their efforts on delivering quality care, even as members of the leadership team move on to other VA facilities or positions.

Figure 2. Facility Organizational Chart



Source: West Texas VA Health Care System (received July 13, 2017).

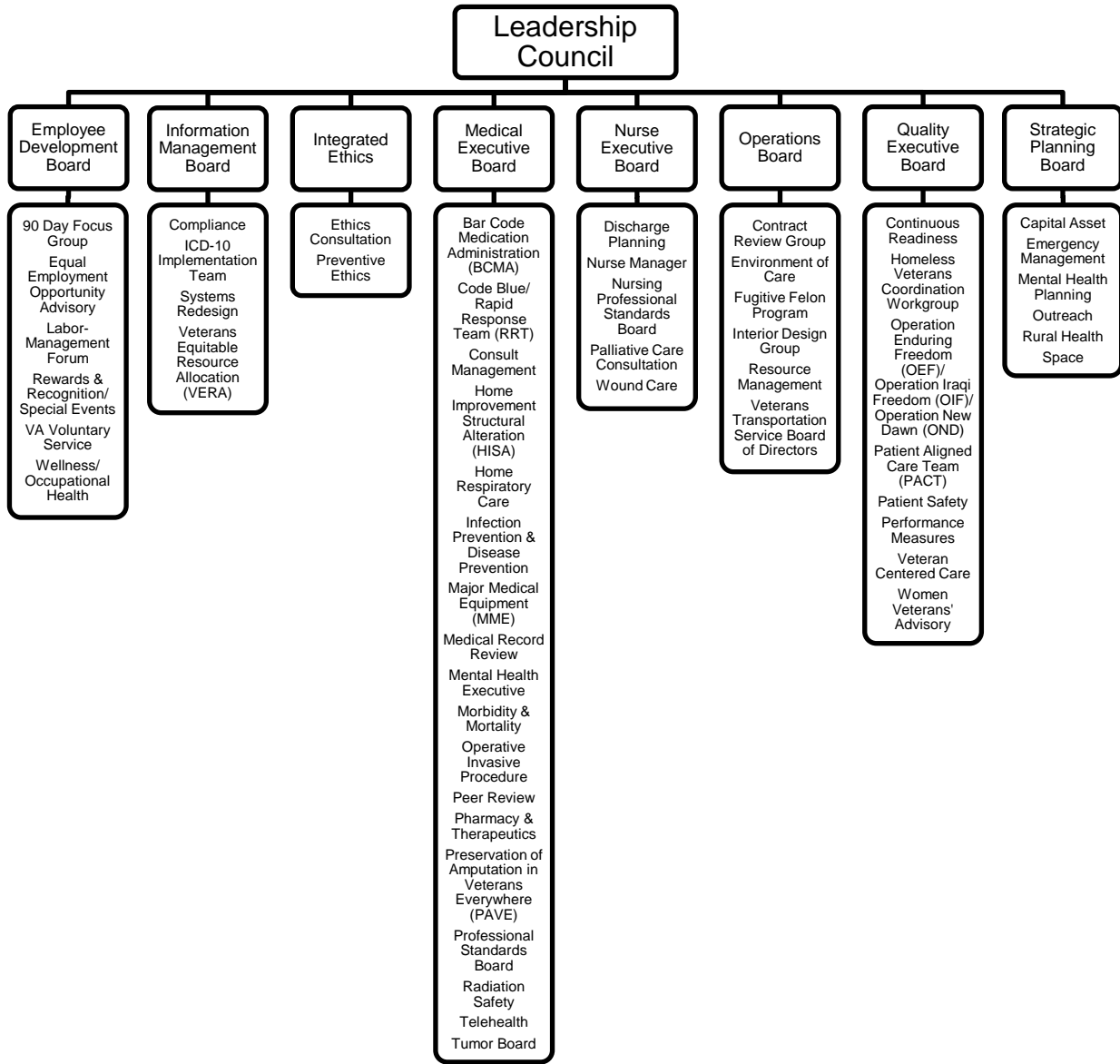
ACOS = Associate Chief of Staff

OEF/OIF = Operation Enduring Freedom/Operation Iraqi Freedom

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Nurse Executive, and Associate Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance. In individual interviews, these executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics, all of which are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility's Leadership Council, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Leadership Council also oversees various working committees, such as the Employee Development Board, Medical Executive Board, and Quality Executive Board. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: West Texas VA Health Care System (received July 13, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period.

The facility leaders’ results (Director’s office average) were rated markedly above the VHA and facility average, and the facility average was similar to the VHA average.⁶ Although employee attitudes were generally satisfied, OIG was told that at the time of the 2016 survey, staff did not “trust” the leadership team because staff felt facility leaders rarely stayed long enough to make a difference. The leadership team is aware of this perception and expects the 2017 survey results to be more favorable because of their efforts to improve communication throughout the facility and CBOCs over the past year.

One of the two outpatient survey results reflected a slightly higher care rating than the VHA average. Facility managers stated that the lack of providers was a contributing factor for the Patient-Centered Medical Home score that was lower than the VHA average. At the time of our visit, we learned that of the 98 facility vacancies, 45 were clinician positions—36 in mental health (MH) and 9 in Primary Care (PC).

Table 1. Survey Results on Employee and Patient Attitudes toward Facility Leadership (October 1, 2015 through September 30, 2016)

Questions	Scoring	VHA Average	Facility Average	Director’s Office Average ⁷
All Employee Survey ⁸ Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.2	4.2
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	66.3	86.7
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.	73.2	62.8	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	74.2	

⁶ 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.

⁷ Rating is based on responses by employees who report to the Director.

⁸ The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

Accreditation/For-Cause⁹ Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC).

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities¹⁰ and College of American Pathologists,¹¹ which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute¹² conducted an inspection of the facility's Community Living Center.

Table 2. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (<i>Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas, November 25, 2014</i>)	September 2014	3	0
VA OIG (<i>Community Based Outpatient Clinic and Primary Care Clinic Reviews at West Texas VA Health Care System, Big Spring, Texas, July 23, 2014</i>)	May 2014	21	0
TJC ¹³ <ul style="list-style-type: none"> • Ambulatory Health Care Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation 	June 2017	13 14 4	13 14 4

The facility has closed¹⁴ the recommendations for improvement issued in the OIG surveys listed; however, they remain open for TJC accreditation inspection. The facility reported that insufficient time has elapsed for it to close TJC recommendations.

⁹ TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

¹⁰ 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.

¹¹ For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

¹² Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

¹³ TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous September 2014 Combined Assessment Program and May 2014 Community Based Outpatient Clinic (CBOC) and PC review inspections through the week of June 19, 2017.

**Table 3. Summary of Selected Organizational Risk Factors¹⁵
(May 2014 to June 19, 2017)**

Factor	Number of Occurrences
Sentinel Events ¹⁶	0
Institutional Disclosures ¹⁷	4
Large-Scale Disclosures ¹⁸	0

The Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services has developed Patient Safety Indicators to provide information on potential in-hospital complications and adverse events following surgeries and procedures.¹⁹ The facility currently does not provide inpatient care, so Patient Safety Indicator data was not collected and available for review.

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.²⁰ This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted

¹⁴ 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 accreditation organization or inspecting agency.

¹⁵ It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the West Texas VA Health Care System is a low complexity (3) affiliated facility as described in Appendix B.)

¹⁶ A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.

¹⁷ Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's 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.

¹⁸ Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

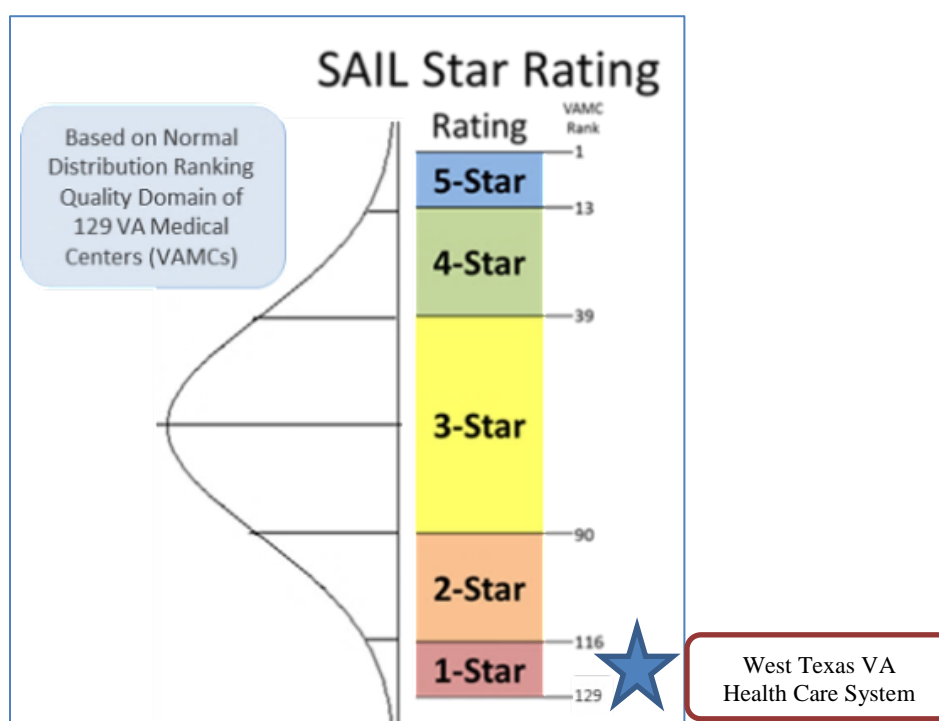
¹⁹ Agency for Healthcare Research and Quality website, <https://www.qualityindicators.ahrq.gov/>, accessed March 8, 2017.

²⁰ The model is derived from the Thomson Reuters Top Health Systems Study.

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.²¹

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the West Texas VA Health Care System received an interim rating of 1 star for overall quality. This means the facility is in the 5th quintile (bottom 10 percent range). Updated data as of June 30, 2017, indicates that the facility has remained at 1 star for overall quality.

Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)

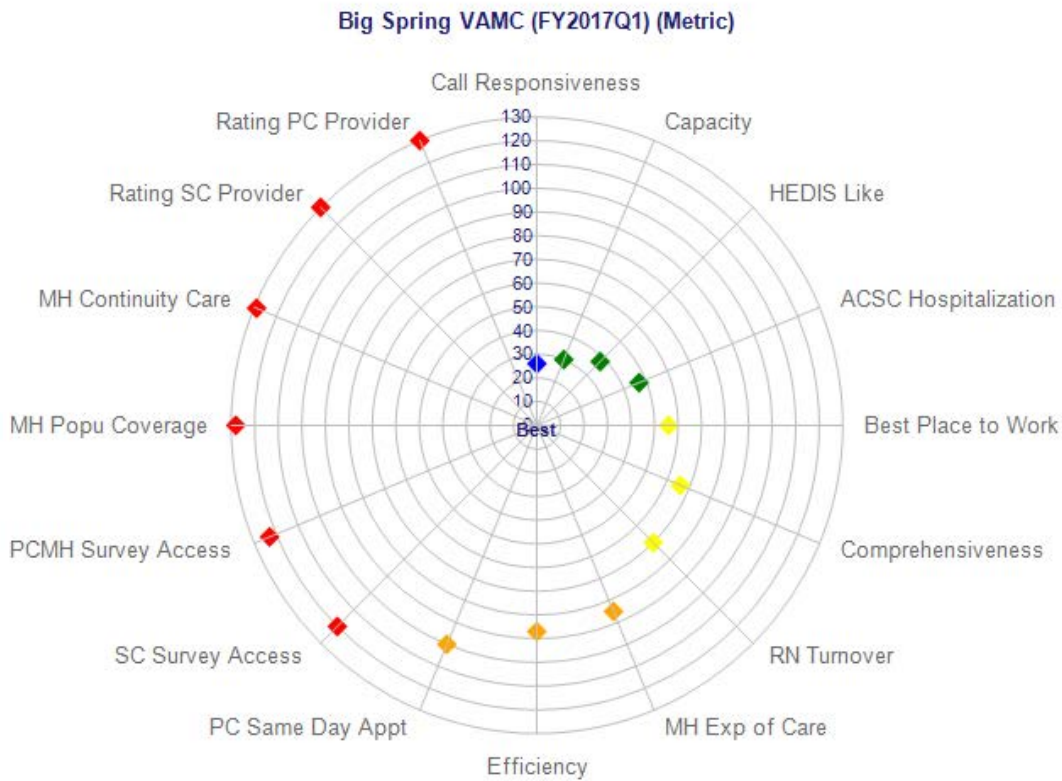


Source: VA Office of Informatics and Analytics’ Office of Operational Analytics and Reporting.

²¹ VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>

Figure 5 illustrates the facility’s Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Call Responsiveness, Capacity, and Outpatient Performance Measure [HEDIS] Like). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Mental Health [MH] Continuity [of] Care, Rating [of] Specialty Care [SC] Providers, and Rating [of] Primary Care [PC] Providers).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2016)



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

Source: VHA Support Service Center.

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

Conclusions. The facility currently has stable executive leadership and active engagement with employees and specialty care outpatients; however, leadership has the opportunity to instill trust and value in the organization by improving the primary care patient experience and overcoming the perceived instability of executive leadership. Additionally, continued staffing vacancies, particularly for MH and PC clinicians, may contribute to future lapses in patient safety unless facility leaders implement processes to attract and retain qualified staff. Organizational leaders support patient safety, quality care, and other positive outcomes. OIG’s review of accreditation organization findings, sentinel events, disclosures, and SAIL results did not identify any substantial organizational risk factors.²² The senior leadership team was knowledgeable about selected SAIL metrics but should take actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 1-star ranking.

²² OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk. OIG is using it as “a way to understand the similarities and differences between the top and bottom performers” within the VHA system.

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.²³ VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

The purpose of this review was to determine whether the facility complied with key QSV program requirements.^a To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review²⁴ of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews²⁵
5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents. The list below shows the performance indicators for each of the following QSV program activities.

- Senior-level committee responsible for key QSV functions
 - Met at least quarterly
 - Chaired or co-chaired by the Facility Director
 - Reviewed aggregated data routinely
- Protected peer reviews
 - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
 - Resulted in implementation of Peer Review Committee recommended improvement actions
- Credentialing and privileging processes
 - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)²⁶ data review
 - Indicated a Focused Professional Practice Evaluation²⁷

²³ Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.

²⁴ According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.

²⁵ According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

²⁶ OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

- Patient safety personnel
 - Entered all reported patient incidents into the WEBSPOOT database
 - Completed the required minimum of eight root cause analyses
 - Reported root cause analysis findings to reporting employees
 - Submitted an annual patient safety report

The area that did not apply to this facility is listed below:

- UM personnel
 - Completed at least 75 percent of all required inpatient reviews
 - Documented Physician UM Advisors' decisions in the National UM Integration database
 - Reviewed UM data using an interdisciplinary group

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

²⁷ Focused Professional Practice Evaluation is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. It typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges. The Focused Professional Practice Evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,²⁸ or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "...anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

Within medication management, OIG selected a special focus on anticoagulation therapy given its risk and common usage among veterans. The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.^b

OIG reviewed relevant documents and the competency assessment records of four employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 25 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

- Development and implementation of anticoagulation management policies
- Algorithms, protocols, or standardized care processes
 - Initiation and maintenance of warfarin
 - Management of anticoagulants before, during, and after procedures
 - Use of weight-based, unfractionated heparin
- Provision of a direct telephone number for patient anticoagulation-related calls
- Designation of a physician anticoagulation program champion
- Risk minimization of dosing errors
- Routine review of quality assurance data
- Provision of transition follow-up and education for patients with newly prescribed anticoagulant medications
- Laboratory testing
 - Prior to initiating anticoagulant medications
 - During anticoagulation treatment
- Documentation of justification/rationale for prescribing the anticoagulant when laboratory values did not meet selected criteria
- Competency assessments for employees actively involved in the anticoagulant program

²⁸ Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusions. OIG found general compliance with requirements for designation of a physician anticoagulation program champion, routine review of quality assurance data, and competency assessments for employees actively involved in the anticoagulant program. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Patient Education. VHA requires clinicians to provide initial and ongoing patient and family education for newly prescribed anticoagulant medications that includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse reactions and interactions. Due to the high risk of adverse events, patient and/or family member education is essential to decrease the potential occurrence of bleeding, drug interactions, or other delayed pharmacological effects, and improve patient compliance. Three of the 25 EHRs did not contain evidence that patients received education specific to the newly prescribed anticoagulant. Clinicians believed that documenting a general statement regarding medication review met requirements and were not aware that education must be specific to the newly prescribed anticoagulant.

Recommendation

1. The Chief of Staff ensures clinicians consistently provide patient education specific for newly prescribed anticoagulant medications and monitors compliance.

Facility Concurred.

Target date for completion: June 1, 2018.

Facility Response: Pharmacy has developed an order set that ensures any patient that is newly prescribed anticoagulation is consistently educated about the indication for therapy, drug and diet interactions, dosage (including proper tablet identification), importance of compliance, management of missed doses, signs and symptoms of bleeding and thromboembolic events and actions to take, informing other providers of long term anticoagulation, informing anticoagulation provider of changes in medication, periprocedural considerations, clinic contact information, and monitoring requirements. Once the education is completed and documented (order template drops documentation into CPRS as progress note), the ordering provider submits the electronic order for warfarin. Pharmacy will monitor that education has been provided for all new anticoagulation patients. The audits will be reported in Pharmacy and Therapeutics Committee monthly until 90% compliance is achieved for 6 months.

Laboratory Tests. VHA requires clinicians to obtain specific laboratory tests such as complete blood count and prothrombin time prior to initiating anticoagulant medications. This ensures patients do not have an underlying medical condition that needs to be addressed prior to receiving the anticoagulant and assists in monitoring patients while on the anticoagulant. In 4 of the 11 applicable EHRs, clinicians did not obtain initial prothrombin/international normalized ratio tests through laboratory testing prior to initiating warfarin. Clinicians and clinical managers were not aware that initial tests

were completed by point-of-care testing rather than the required blood draw. In addition, a lack of attention to detail by clinicians resulted in instances where, although tests were ordered, clinicians did not verify whether the tests were completed prior to initiating the medication.

Recommendation

2. The Chief of Staff ensures clinicians consistently obtain all required laboratory tests prior to initiating warfarin and monitors compliance.

Facility Concurred

Target date for completion: May 1, 2018.

Facility Response: Pharmacy has developed an order set which prevents direct ordering of warfarin. Providers are prompted by means of the required order set to order a serum INR/CBC and confirm the blood test has been drawn. Pharmacy will monitor that INR/CBCs have been completed on all new anticoagulation patients which will be reported in Pharmacy and Therapeutics Committee monthly until 90% compliance is achieved for 6 months.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately under circumstances that provide maximum safety for patients and comply with applicable standards.

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.^c

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 49 randomly selected patients who were transferred out of the facility's urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

- Development and implementation of patient transfer policy
- Collection and reporting of data about transfers out of the facility
- Completion of VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer
 - Date of transfer
 - Patient or surrogate informed consent
 - Medical and/or behavioral stability
 - Identification of transferring and receiving provider or designee
 - Details of the reason for transfer or proposed level of care needed
- Documentation by acceptable designees in the absence of staff/attending physicians
 - Staff/attending physician approval
 - Staff/attending physician countersignature on the transfer note
- Nurse documentation of transfer assessments/notes
- Provider documentation for emergent transfers
 - Patient stability for transfer
 - Provision of all medical care within the facility's capacity
- Communication with the accepting facility
 - Available history
 - Observations, signs, symptoms, and preliminary diagnoses
 - Results of diagnostic studies and tests

Conclusions. OIG noted that the facility developed and implemented a patient transfer policy. However, OIG identified the following deficiencies with documentation and communication of all required elements for patient transfers to accepting facilities.

Transfer Documentation. For emergent transfers, VHA requires transferring providers to document the patient's stability for transfer and the provision of all medical care within the facility's capacity. This prevents a facility from transferring a patient with an emergency medical condition before the condition is stabilized. In two of the six applicable EHRs, provider transfer notes did not document patient stability for transfer and provision of all medical care within the facility's capacity. Managers knew the requirements, but they perceived that the documentation of a verbal conversation regarding the care of the patient, which is also expected to occur between facility providers and accepting providers, was sufficient.

Recommendation

3. The Chief of Staff ensures that for emergent transfers, provider transfer notes document patient stability for transfer and provision of all medical care within the facility's capacity and monitors providers' compliance.

Facility Concurred.

Target date for completion: May 1, 2018.

Facility Response: The Chief of Staff has ensured that for emergent transfers, provider transfer notes will document patient stability for transfer and provision of medical care within the facility's capability by implementing a transfer template note that will result in uniformity of documentation of all emergent transfers. Each clinic manager will complete audits on 100% of emergent transfers to ensure that the documentation is 90% compliant for six months. This audit will be reported monthly to the Medical Executive Board.

Communication with Accepting Facility. For inter-facility transfers, VHA requires that the communication with the accepting facility or the documentation sent includes pertinent patient information. Communication of relevant information ensures continuity of care for patients transferred out of VHA facilities. OIG did not find evidence that providers sent or communicated pertinent patient information in 14 of 49 EHRs (29 percent). Managers knew the requirements, but they perceived that verbal communication between facility providers and accepting providers and nurse-to-nurse contact was sufficient.

Recommendation

4. The Chief of Staff ensures that for patients transferred out of the facility, providers document sending or communicating to the accepting facility pertinent patient information and monitors providers' compliance.

Facility Concurred.

Target date for completion: May 1, 2018.

Facility Response: The Chief of Staff has ensured that for patients transferred out of the facility, providers document sending or communicating to the accepting facility pertinent patient information by implementing a transfer template note that will result in uniformity of documentation of all transfers. Each clinic manager will complete audits on 100% of transfers until the documentation is 90% compliant for six months. This audit will be reported monthly to the Medical Executive Board.

Environment of Care

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service.^d

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.²⁹ Although an integral part of health care, fluoroscopic imaging can deliver large doses of radiation to patients and employees. Large doses of radiation are known to increase the incidence of cancer and can cause fetal abnormalities.

VHA provides various MH services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.³⁰ The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected dental, ophthalmology, audiology, MH and PC clinics, the community living center, the urgent care clinic, and Radiology Service. OIG also inspected the Stamford CBOC. Additionally, OIG reviewed relevant documents and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

Parent Facility

- EOC deficiency tracking
- EOC rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

²⁹ VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.

³⁰ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

Community Based Outpatient Clinic

- General safety
- Infection prevention
- Environmental cleanliness
- Medication safety and security
- Exam room privacy
- General privacy
- Availability of feminine hygiene products
- IT network room security
- Availability of medical equipment and supplies

Radiology

- Safe use of fluoroscopy equipment
- Environmental safety
- Infection prevention
- Medication safety and security
- Radiology equipment inspection
- Availability of medical equipment and supplies
- Maintenance of radiological equipment

The area that did not apply to this facility is listed below.

Locked Mental Health Unit

- MH EOC inspections
- Environmental suicide hazard identification and abatement
- Environmental safety
- Infection prevention
- Employee training on MH environmental hazards
- Availability of medical equipment and supplies

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

Mental Health Residential Rehabilitation Treatment Program

For this facility, OIG evaluated the MH Residential Rehabilitation Treatment Program (RRTP), more commonly referred to as domiciliary or residential treatment programs. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home care as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.³¹

The purpose of the review was to determine whether the facility's MH RRTPs complied with selected EOC requirements.^e

OIG reviewed relevant documents, inspected the MH RRTP, and interviewed key employees and managers. The list below shows the performance indicators OIG reviewed.

- Environmental cleanliness
- Appropriate fire extinguishers near grease producing cooking devices
- Policies/procedures for safe medication management and contraband detection
- Performance and documentation of monthly self-inspections to include all required elements, work orders for items needing repair, and correction of identified deficiencies
- Performance and documentation of contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications
- Written agreements in place acknowledging resident responsibility for medication security
- Keyless entry to MH RRTP main point(s) of entry, closed circuit television monitoring, and all other doors locked to outside and alarmed
- Closed circuit television (CCTV) monitors with recording capability in public areas but not in treatment areas or private spaces
- Signage alerting veterans and visitors of recording
- Process for employees to respond and articulate behavioral health and medical emergencies

³¹ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

- Keyless entry or door locks to women veterans' rooms
- Medications secured in residents' rooms

Conclusions. Generally, OIG found compliance with cleanliness. However, during inspections of the MH RRTP areas, OIG identified the following deficiencies that warranted recommendations for improvement.

Monthly Self-Inspections. VHA requires MH RRTP employees to conduct at least one formal safety, security, and privacy self-inspection each month and to document observations, work orders submitted, and corrective actions taken. This ensures residential environments are safe, secure, and appropriately furnished and receive timely repairs and regular maintenance. We reviewed 6 months (January through June 2017) of self-inspection documentation and did not find details of the observations and deficiencies found, work orders submitted, or evidence of actions taken to correct deficiencies. Program staff and managers referred OIG to additional spreadsheets that included some of the work orders submitted; however, these spreadsheets did not identify the actions taken. A lack of organization and attention to detail resulted in noncompliance.

Recommendation

5. The Chief of Staff ensures that Mental Health Residential Rehabilitation Treatment Program employees document details of the observations and deficiencies identified during monthly self-inspections, submit work orders for all items needing repair, and document corrective actions taken, and the Chief of Staff monitors employees' compliance.

Facility Concurred.

Target date for completion: January 1, 2018.

Facility Response: The Chief of Staff has ensured that Mental Health Residential Rehabilitation Treatment Program employees document details of the observations and deficiencies identified during monthly self-inspections. The Monthly Safety Champion reviewed the checklist for observations and deficiencies monitored due by 5th of the month. Work orders are submitted by staff who identified the issue and monitored to completion by the Program Support Assistant (PSA) and Rehabilitation Tech. Monthly ongoing review of all outstanding open work orders and follow-up by PSA. The Program Administrator monitored repairs and documentation of corrective actions since June 2017 and determined that the facility met requirements. We request closure of this recommendation based on evidence provided.

Weekly Contraband Inspections. VHA requires MH RRTP employees to conduct random, weekly contraband inspections on a minimum of 10 percent of all resident rooms, lockers, and drawers. Contraband refers to goods that are prohibited on the unit including, but not limited to, weapons, illegal drugs, and alcohol. Weekly contraband inspections help promote an environment where patients, staff, and visitors feel safe and secure. We reviewed documentation of contraband inspections conducted from

January 1, 2017 through June 20, 2017. For 17 of the 23 weeks, MH RRTP employees did not conduct contraband inspections. Program managers were aware of the requirements and reported that the staff responsible for contraband checks had been on extended leave. Managers failed to develop an interim staff coverage plan to ensure compliance.

Recommendation

6. The Chief of Staff ensures that Mental Health Residential Rehabilitation Treatment Program employees consistently conduct and document weekly contraband inspections and monitors employees' compliance.

Facility Concurred.

Target date for completion: January 1, 2018.

Facility Response: The Chief of Staff has ensured that Mental Health Residential Rehabilitation Treatment Program employees completed random weekly contraband checks in 10% of the rooms. Documentation from the Contraband Checklist Tool was monitored by the Program Manager to ensure compliance. In the absence of the Program Manager, the Program Support Assistant monitors compliance. If issues are identified, counseling will be completed by the Program Manager with the staff and/or resident. The Program Administrator monitored weekly performance and documentation of contraband inspections from August – December 2017 and determined that the facility met requirements. We request closure based on evidence provided.

Staff and Patient Safety. VHA requires that MH RRTP doors not considered main points of entry be alarmed and locked to the outside. This ensures patient and staff safety and alerts staff to an emergency or unauthorized door opening from the inside. The MH RRTP's alarm system for non-main entry/exit doors fed directly into the nursing station's computer. The alarm was barely audible for those sitting directly in front of the nursing station computer and was not audible for others in any other area on the unit. When tested while OIG was onsite, program staff were unaware that an alarm had been set off. Program managers were aware of the requirement and stated they were in the process of researching appropriate alarms for the doors; however, at the time of the inspection, no purchase was approved and no order had been placed.

Recommendation

7. The Associate Director ensures that Mental Health Residential Rehabilitation Treatment Program managers ensure that all doors not considered as the main point of entry have audible alarms and monitors managers' compliance.

Facility Concurred.

Target date for completion: December 15, 2017.

Facility Response: The Associate Director has confirmed that exit audible alarms have been installed. The Chief of Engineering and Life Safety Officer have verified that the audible alarms installed on all doors that are not considered as the main point of entry can be heard throughout the building. All doors not considered as the main point of entry had audible alarms installed on December 15, 2017. We request closure of this recommendation based on evidence provided.

Post-Traumatic Stress Disorder Care

For this facility, OIG also evaluated post-traumatic stress disorder (PTSD), a disorder that may occur "...following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."³²

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

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

The purpose of this review was to assess whether the facility complied with selected VHA requirements for PTSD follow-up in the outpatient setting.

OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 48 randomly selected patients who had a positive PTSD screen from April 1, 2016 through March 31, 2017. The list below shows the performance indicators OIG reviewed.

- Completion of a suicide risk assessment by acceptable providers
- Establishment of plan of care and disposition
- Offer of further diagnostic evaluations
- Completion of diagnostic evaluations
- Receipt of MH treatment when applicable

Conclusion. Generally, the facility did not meet requirements with the above performance indicators. OIG identified deficiencies in acceptable providers performing and documenting suicide risk assessments, offering further diagnostic evaluations, and completing diagnostic evaluations within 30 days for all patients with positive post-traumatic stress disorder screens. Additionally, OIG found a deficiency with required documentation of resident supervision in the electronic health record.

³² VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.

Suicide Risk Assessment. VHA requires that patients with positive PTSD screens are assessed for suicide risk by an appropriate provider. This ensures that immediate safety risks are identified and addressed. Six of the 48 EHRs (13 percent) did not contain evidence of suicide risk assessments. OIG noted a lack of communication between the employee conducting the initial screen and the provider responsible for addressing all positive PTSD screens. When the initial screener does not sign the notes prior to the patient seeing the provider, the provider is not automatically alerted to address positive PTSD screens. This situation necessitates communication between the screener and provider to ensure follow-up of the positive PTSD screen. Clinical managers did not provide effective oversight to ensure compliance with VHA requirements.

Recommendation

8. The Chief of Staff ensures that acceptable providers perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens and monitors providers' compliance.

Facility Concurred.

Target date for completion: August 2018.

Facility Response: The Chief of Staff will ensure that acceptable providers (Mental Health, Home Based Primary Care, and Primary Care) perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screen. A post-traumatic stress disorder follow up positive clinical reminder report will be generated by Business Information Systems daily and sent to each Primary Care team, Mental Health group, and Home Based Primary Care. This will allow for any positive reminder that was missed during the day to be addressed within 24 hours of a positive screen. Education to all clinicians and teams will occur by January 19, 2018. The Chief of Mental Health, Associate Chief of Staff, Ambulatory Care and Home Based Primary Care Administrator will ensure monitoring through a random review of 30 charts monthly to be reported to Quality Executive Board until 90% compliance is achieved for six months.

Diagnostic Evaluations and Referrals. VHA requires that patients who screen positive for PTSD are further evaluated either by a PC provider or by referral to a MH clinician. This ensures early identification and management of stress-related disorders. In 8 of the 48 EHRs (17 percent), acceptable providers did not document offers of further diagnostic evaluations. OIG noted that for six of these eight patients, PC providers documented the need for further evaluation and their plan to place a MH consult; however, no referral or consult was ever placed. A lack of attention to detail and follow through by PC providers resulted in noncompliance.

Recommendation

9. The Chief of Staff ensures that acceptable providers offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens and refer them and monitors providers' compliance.

Facility Concurred.

Target date for completion: August 2018.

Facility Response: The Chief of Staff will ensure that providers perform and enter mental health consults for patients with positive post-traumatic stress disorder screen as clinically indicated and with Veteran consent. A post-traumatic stress disorder positive clinical reminder report will be generated by Business Information Service daily and sent to each Primary Care Team, Mental Health Group, and Home Based Primary Care. This will allow for monitoring of the providers' compliance with diagnostic evaluations and submission of consults as clinically indicated and with Veteran consent. In the event the evaluations and/or consults were not completed as indicated in the clinical record, immediate feedback can be given to providers to correct within 24 hours of the positive screen. Education to all clinicians and teams will occur by January 19, 2018. The Chief of Mental Health, Associate Chief of Staff, Ambulatory Care and Home Based Primary Care Administrator will ensure monitoring through a random review of 30 charts to be reported to Quality Executive Board until a 90% compliance is achieved for six months.

Diagnostic Evaluation Completion. VHA requires that patients referred for MH services receive a full evaluation within 30 days. This is to ensure patients with PTSD or other MH conditions receive timely services designed to meet their clinical needs. In 6 of the 19 applicable EHRs, providers did not complete clinical diagnostic evaluations within 30 days. Clinical managers cited the lack of staff and the difficulty of recruiting and retaining MH clinicians as contributing factors for noncompliance with the timeliness requirement.

Recommendation

10. The Chief of Staff ensures that acceptable providers complete diagnostic evaluations within 30 days for patients with positive post-traumatic stress disorder screens and monitors providers' compliance.

Facility Concurred.

Target date for completion: August 2018.

Facility Response: The Chief of Staff will ensure that providers complete MH diagnostic evaluations within 30 days for patients with a positive post-traumatic stress disorder (PTSD) screen. The Chief of Mental Health will ensure all Veterans are seen within 30 days of consult. Additional providers have been hired to provide coverage for prior clinics that previously could not support consults within 30 days. All consults to include positive post-traumatic stress disorder screens are being reviewed and Veterans are being offered appointments within 30 days. The Chief of Mental Health will randomly audit 30 charts monthly and report to Quality Executive Board until 90% compliance is achieved for six months.

Resident Supervision Documentation. VHA requires staff/attending physicians to document in the EHRs their involvement in and supervision of each type of resident-patient encounter. Documentation of supervision (co-signature, addendum, or independent progress note) must be entered by the supervising physician or reflected within the resident progress note. This ensures that patients are cared for by clinicians who are qualified to deliver the care and that the care is documented appropriately and accurately. Of the 48 EHRs, 7 (15 percent) contained a progress note documented by a resident physician. Two of the seven progress notes were co-signed by the residents for the supervising physician. This is incongruent with VHA policy. Facility managers stated that this occurred because residents were incorrectly granted a user class computer option that allowed the capability of co-signing their own notes. Facility managers took immediate action by reassigning residents the correct user class computer option and reporting the incident to the VA Compliance and Business Integrity Helpline as a compliance inquiry.

Recommendation

11. The Chief of Staff ensures that resident physicians are assigned and granted the correct user class computer option and that clinical managers review and monitor residents' progress notes to ensure that resident supervision documentation meets requirements, and the Chief of Staff monitors managers' compliance.

Facility Concurred.

Target date for completion: Completed.

Facility Response: The Chief of Staff has ensured that resident physicians are assigned and granted the student user class computer option only. Associate Chief of Staff for Education will review and monitor residents' progress notes to ensure that resident supervision documentation meets requirements. A retrospective review for the last 5 months reflects a 100% compliance rate. We request closure based on evidence provided.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings			
Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	<ul style="list-style-type: none"> • Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data 	Eleven OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Chief of Staff and Associate Director. See details below.	
Healthcare Processes	Performance Indicators	Critical Recommendations³³ for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses 	None	None
Medication Management	<ul style="list-style-type: none"> • Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants <ul style="list-style-type: none"> ○ Prior to treatment ○ During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment 	<ul style="list-style-type: none"> • Clinicians consistently provide patient education specific for newly prescribed anticoagulant medications. • Clinicians consistently obtain all required laboratory tests prior to initiating warfarin. 	None

³³ OIG defines “critical recommendations” as those that rise above others and address vulnerabilities and risks that could cause exceptionally grave health care outcomes and/or significant impact to quality of care.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Coordination of Care	<ul style="list-style-type: none"> • Transfer policies and procedures • Oversight of transfer process • EHR documentation <ul style="list-style-type: none"> ○ Non-emergent transfers ○ Emergent transfers 	<ul style="list-style-type: none"> • For emergent transfers, provider transfer notes document patient stability and provision of all medical care within the facility's capacity. • For patients transferred out of the facility, providers document sending or communicating to the accepting facility pertinent patient information. 	None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> • Parent facility <ul style="list-style-type: none"> ○ EOC deficiency tracking and rounds ○ General Safety ○ Infection prevention ○ Environmental cleanliness ○ Exam room privacy ○ Availability of feminine hygiene products and medical equipment and supplies • CBOC <ul style="list-style-type: none"> ○ General safety ○ Infection prevention ○ Environmental cleanliness ○ Medication safety and security ○ Privacy ○ Availability of feminine hygiene products and medical equipment and supplies ○ IT network room security • Radiology <ul style="list-style-type: none"> ○ Safe use of fluoroscopy equipment ○ Environmental safety ○ Infection prevention ○ Medication safety and security ○ Radiology equipment inspection ○ Availability of medical equipment and supplies ○ Maintenance of radiological equipment • Inpatient MH <ul style="list-style-type: none"> ○ MH EOC inspections ○ Environmental suicide hazard identification ○ Employee training ○ Environmental safety ○ Infection prevention ○ Availability of medical equipment and supplies 	None	None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<p>High-Risk and Problem-Prone Processes: Mental Health Residential Rehabilitation Treatment Program</p>	<ul style="list-style-type: none"> • Environmental cleanliness and fire safety • Policies/procedures <ul style="list-style-type: none"> ○ Safe medication management ○ Contraband detection • Monthly self-inspections • Contraband and unsecured medication inspections • Locked and alarmed entries • Closed circuit television monitors with recording capability in public areas • Process for responding to behavioral health and medical emergencies 	<ul style="list-style-type: none"> • Employees consistently conduct and document weekly contraband inspections. • Managers ensure that all doors not considered as the main point of entry have audible alarms to alert employees of unauthorized door opening. 	<ul style="list-style-type: none"> • Employees document details of the observations and deficiencies identified during monthly self-inspections, submit work orders for all items needing repair, and document corrective actions taken.
<p>High-Risk and Problem-Prone Processes: Post-Traumatic Stress Disorder Care</p>	<ul style="list-style-type: none"> • Completion of a suicide risk assessment by acceptable providers • Established plan of care and disposition • Offer of further diagnostic evaluations • Completion of diagnostic evaluations • Receipt of MH treatment when applicable 	<ul style="list-style-type: none"> • Acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens. • Acceptable providers offer further diagnostic evaluations to patients with positive PTSD screens and refer them. • Acceptable providers complete diagnostic evaluations within 30 days for patients with positive PTSD screens. 	<ul style="list-style-type: none"> • Resident physicians are assigned and granted the correct user class computer option and that clinical managers review and monitor residents' progress notes to ensure that resident supervision documentation meets requirements.

Facility Profile

The table below provides general background information for this low-complexity (3)³⁴ affiliated³⁵ facility reporting to VISN 17.

Table 5. Facility Profile for Big Spring (519) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014 ³⁶	Facility Data FY 2015 ³⁷	Facility Data FY 2016 ³⁸
Total Medical Care Budget in Millions	\$114.2	\$136.6	\$129.2
Number of:			
• Unique Patients	17,193	17,467	18,360
• Outpatient Visits	159,570	166,492	177,178
• Unique Employees³⁹	380	400	438
Type and Number of Operating Beds:			
• Acute	NA	NA	NA
• Mental Health	NA	NA	NA
• Community Living Center	40	40	40
• Domiciliary	40	40	40
Average Daily Census:			
• Acute	NA	NA	NA
• Mental Health	NA	NA	NA
• Community Living Center	23	20	24
• Domiciliary	31	30	29

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

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

NA = Not applicable

³⁴ VHA medical centers are classified according to a facilities complexity model; 3 designation indicates a facility with low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs. Retrieved September 7, 2017, from <http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx>

³⁵ Associated with a medical residency program.

³⁶ October 1, 2013 through September 30, 2014.

³⁷ October 1, 2014 through September 30, 2015.

³⁸ October 1, 2015 through September 30, 2016.

³⁹ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles⁴⁰

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women’s health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 6 provides information relative to each of the clinics.

Table 6. VA Outpatient Clinic Workload/Encounters⁴¹ and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/Encounters	MH Workload/Encounters	Specialty Care Services ⁴² Provided	Diagnostic Services ⁴³ Provided	Ancillary Services ⁴⁴ Provided
Odessa, TX	519GA	10,135	2,683	Poly-Trauma Eye	NA	Nutrition Pharmacy Weight Management
Hobbs, NM	519GB	2,171	809	Eye	NA	Nutrition Pharmacy
Fort Stockton, TX	519GD	571	NA	NA	NA	NA
Abilene, TX	519HC	12,878	3,691	Dermatology Poly-Trauma Eye	NA	Nutrition Pharmacy
Stamford, TX	519HD	257	NA	NA	NA	NA
San Angelo, TX	519HF	7,578	3,944	Poly-Trauma Eye	NA	Nutrition Pharmacy

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

NA = Not applicable

⁴⁰ Includes all outpatient clinics in the community that were in operation as of February 15, 2017.

⁴¹ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.

⁴² Specialty care services refer to non-PC and non-MH services provided by a physician.

⁴³ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

⁴⁴ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

In this report, OIG cited five policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
3. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010 (recertification due date December 31, 2015).
4. VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (recertification due date March 31, 2015) (revised December 8, 2015).⁴⁵
5. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010 (recertification due date December 31, 2015).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),⁴⁶ the VA Under Secretary for Health mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."⁴⁷ The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "...the timely rescission or recertification of policy documents over which their program offices have primary responsibility."⁴⁸

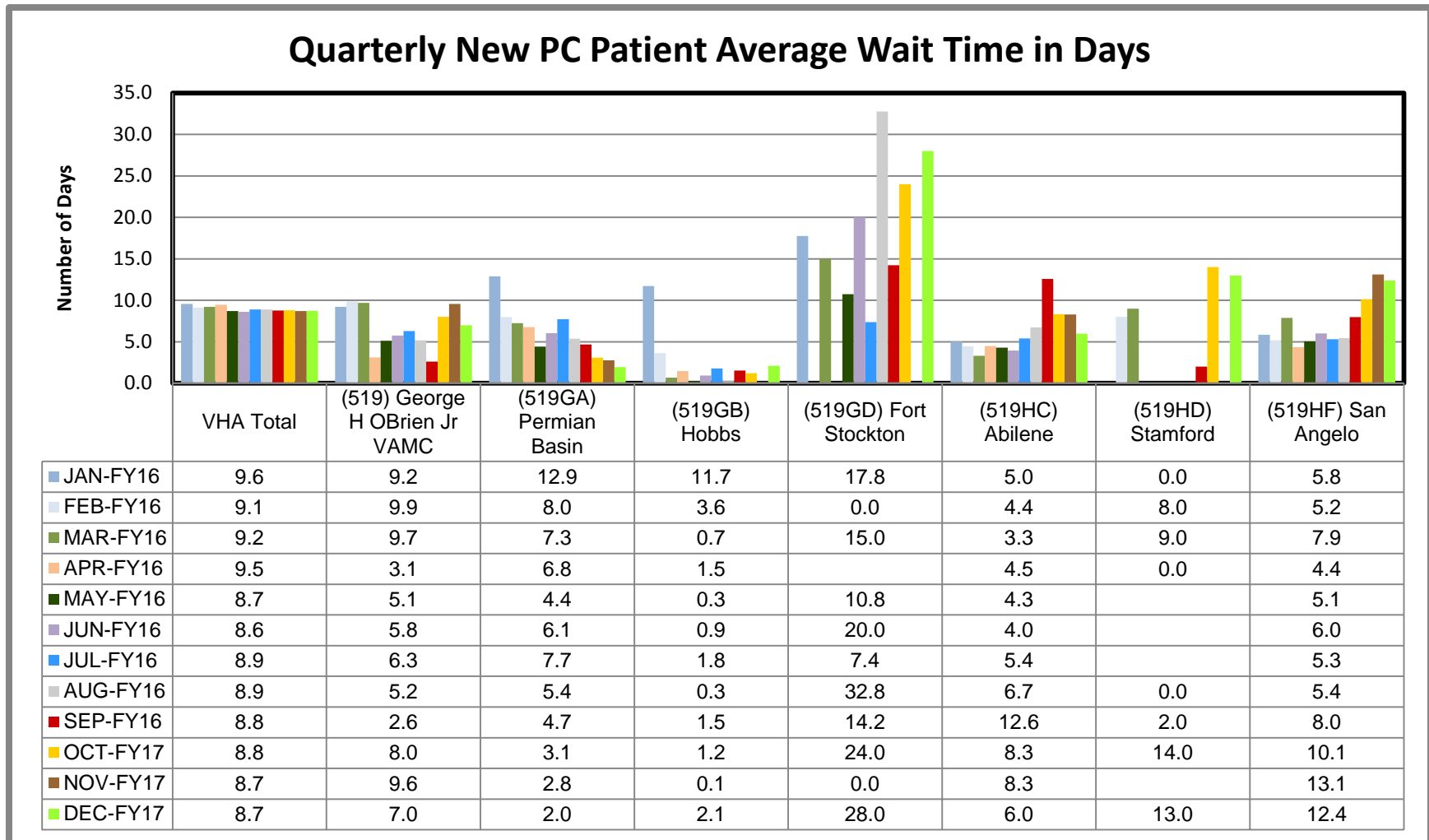
⁴⁵ This handbook was in effect during the review period for this report; it was rescinded and replaced by VHA Directive 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, November 16, 2017.

⁴⁶ VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

⁴⁷ VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.

⁴⁸ Ibid.

Patient Aligned Care Team Compass Metrics

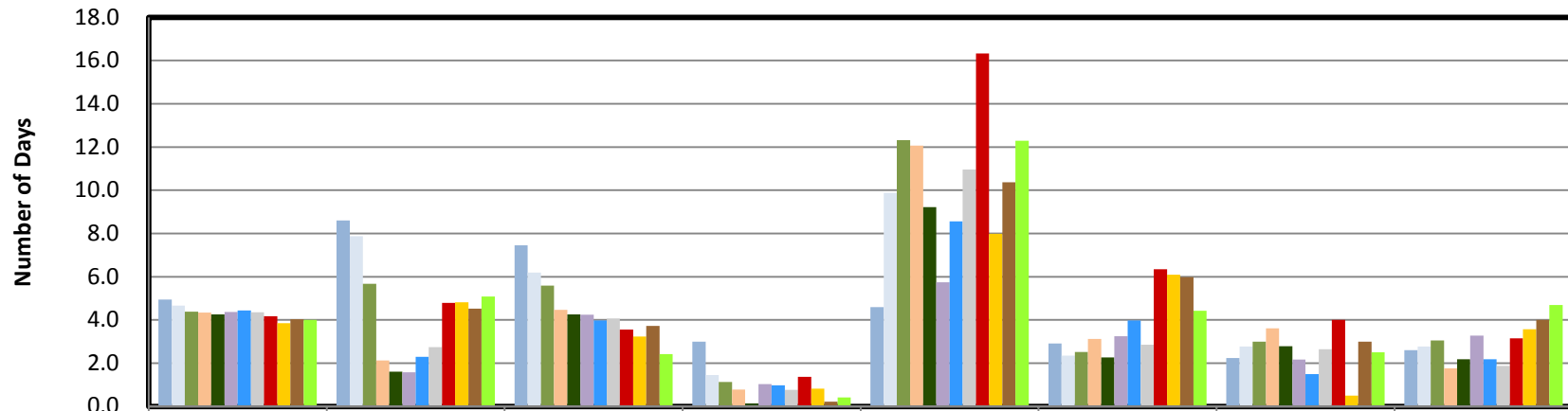


Source: VHA Support Service Center.

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

Data Definition⁶: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.* Blank cells indicate the absence of reported data.

Quarterly Established PC Patient Average Wait Time in Days



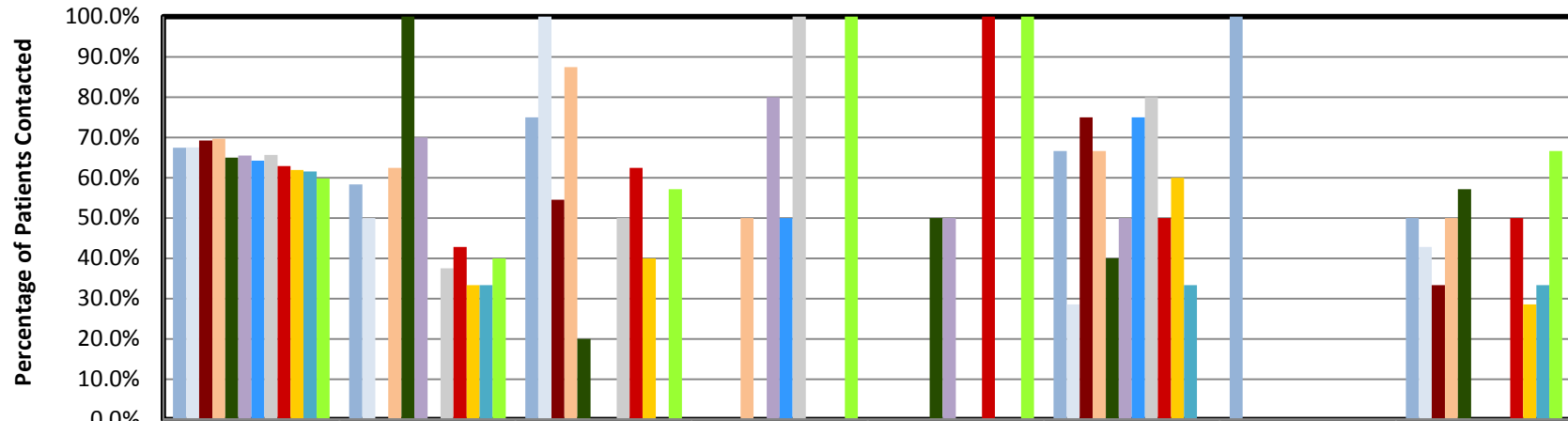
	VHA Total	(519) George H O'Brien Jr VAMC	(519GA) Permian Basin	(519GB) Hobbs	(519GD) Fort Stockton	(519HC) Abilene	(519HD) Stamford	(519HF) San Angelo
JAN-FY16	4.9	8.6	7.5	3.0	4.6	2.9	2.2	2.6
FEB-FY16	4.7	7.9	6.2	1.5	9.9	2.3	2.8	2.8
MAR-FY16	4.4	5.7	5.6	1.1	12.3	2.5	3.0	3.0
APR-FY16	4.3	2.1	4.5	0.8	12.1	3.1	3.6	1.8
MAY-FY16	4.3	1.6	4.2	0.1	9.2	2.3	2.8	2.2
JUN-FY16	4.4	1.6	4.2	1.0	5.7	3.2	2.2	3.3
JUL-FY16	4.4	2.3	4.0	1.0	8.6	4.0	1.5	2.2
AUG-FY16	4.3	2.7	4.1	0.8	11.0	2.9	2.6	1.9
SEP-FY16	4.2	4.8	3.6	1.4	16.3	6.3	4.0	3.1
OCT-FY17	3.8	4.8	3.2	0.8	8.0	6.1	0.5	3.6
NOV-FY17	4.0	4.5	3.7	0.2	10.4	6.0	3.0	4.0
DEC-FY17	4.0	5.1	2.4	0.4	12.3	4.4	2.5	4.7

Source: VHA Support Service Center.

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

Data Definition: The average number of calendar days between an established patient’s PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.

Quarterly Team 2-Day Post Discharge Contact Ratio



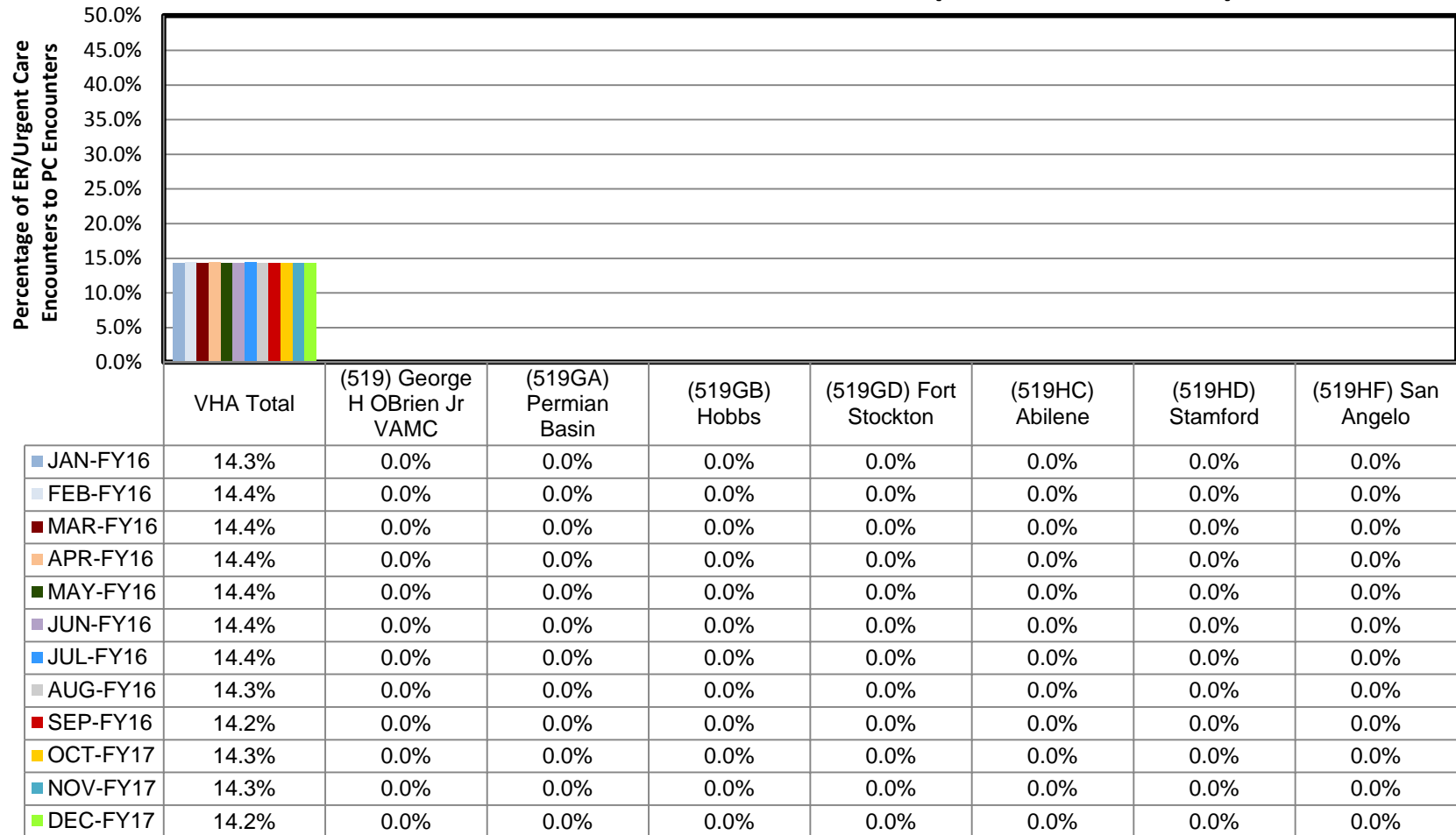
	VHA Total	(519) George H O'Brien Jr VAMC	(519GA) Permian Basin	(519GB) Hobbs	(519GD) Fort Stockton	(519HC) Abilene	(519HD) Stamford	(519HF) San Angelo
JAN-FY16	67.5%	58.3%	75.0%	0.0%		66.7%	100.0%	50.0%
FEB-FY16	67.6%	50.0%	100.0%			28.6%		42.9%
MAR-FY16	69.2%	0.0%	54.5%	0.0%	0.0%	75.0%		33.3%
APR-FY16	69.7%	62.5%	87.5%	50.0%		66.7%		50.0%
MAY-FY16	65.0%	100.0%	20.0%		50.0%	40.0%		57.1%
JUN-FY16	65.5%	70.0%	0.0%	80.0%	50.0%	50.0%		
JUL-FY16	64.3%	0.0%	0.0%	50.0%		75.0%		0.0%
AUG-FY16	65.7%	37.5%	50.0%	100.0%		80.0%		
SEP-FY16	62.9%	42.9%	62.5%		100.0%	50.0%		50.0%
OCT-FY17	62.0%	33.3%	40.0%		0.0%	60.0%		28.6%
NOV-FY17	61.6%	33.3%	0.0%			33.3%	0.0%	33.3%
DEC-FY17	59.9%	40.0%	57.1%	100.0%	100.0%	0.0%		66.7%

Source: VHA Support Service Center.

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

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient’s team at the time of the patient’s discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic “PACT17.” Blank cells indicate the absence of reported data.

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



Source: VHA Support Service Center.

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

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

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions^h

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value

Measure	Definition	Desired Direction
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center.

Relevant OIG Reports

May 13, 2014 through January 1, 2018⁴⁹

Review of VHA Care and Privacy Standards for Women Veterans

6/19/2017 | 15-03303-206 | [Summary](#) | [Report](#)

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

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

Healthcare Inspection – Review of Antimicrobial Stewardship Programs in VHA Facilities

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

Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas

11/25/2014 | 14-02080-29 | [Summary](#) | [Report](#)

Community Based Outpatient Clinic and Primary Care Clinic Reviews at West Texas VA Health Care System, Big Spring, Texas

7/23/2014 | 14-00916-218 | [Summary](#) | [Report](#)

⁴⁹ These are relevant reports that focused on the facility as well as national-level evaluations of which the facility was a component of the review.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 11, 2017

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

**Subject: CHIP Review of the West Texas VA Health Care System,
Big Spring, TX**

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

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

Thank you for the opportunity to review and respond to: CHIP DRAFT report for the West Texas Veterans Health Care System, Big Spring, TX.

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



Jeff Milligan

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

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum


Date: December 7, 2017

From: Director, West Texas VA Health Care System, Big Spring, TX
(519/00)

Subject: **CHIP Review of the West Texas VA Health Care System,
Big Spring, TX**

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

1. I would like to express my appreciation to the Office of the Inspector General (OIG), Comprehensive Healthcare Inspection Program (CHIP) review team for their professionalism and excellent feedback provided to our employees during the CHIP review conducted June 19-22, 2017.
2. I have reviewed the recommendations and the findings. Our comments and action plans to the 11 recommendations are attached.



Kalautie JangDhari
Director

OIG Contact and Staff Acknowledgments

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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: John Cornyn, Ted Cruz, Martin Heinrich, Tom Udall
U.S. House of Representatives: Jodey Arrington, John Carter, K. Michael Conaway, Michelle Luján Grisham, Will Hurd, Ben Ray Luján, Beta O'Rourke, Steve Pearce, Lamar Smith, Mac Thornberry, Roger Williams

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

Endnotes

^a The references used for QSV were:

- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

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

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

^c The references used for Coordination of Care: Inter-Facility Transfers included:

- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007. This directive was in effect during the timeframe of OIG's review but has been rescinded and replaced with VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

^d The references used for EOC included:

- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticervices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, <http://vaww.ncps.med.va.gov/guidelines.html#mhc>, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

^e The references used for MH RRTP were:

- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

^f The references used for PTSD Care included:

- VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
- VA Memorandum, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 2015.
- *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, Version 2.0, October 2010.
- *VHA Technical Manual – PTSD*, VA Measurement Manual PTSD-51.

^g The reference used for PACT Compass data graphs was:

- Department of Veterans' Affairs, *Patient Aligned Care Teams Compass Data Definitions*, accessed: April 28, 2017.

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

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