Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-01876-252

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

September 21, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

ADC	average daily census
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CDC	Centers for Disease Control and Prevention
CLC	community living center
CRD	chronic renal disease
EOC	environment of care
ESA	erythropoiesis-stimulating agent
facility	El Paso VA Health Care System
FTE	full-time employee equivalents
FY	fiscal year
g/dL	grams per deciliter
IC	infection control
JC	Joint Commission
MRI	magnetic resonance imaging
NAPR	negative air pressure room
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PI	performance improvement
QM	quality management
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WBAMC	William Beaumont Army Medical Center

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Executive Summary: Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of May 17, 2010.

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

- Physician Credentialing and Privileging
- Magnetic Resonance Imaging Safety
- Reusable Medical Equipment

Recommendations: We made recommendations in the following four activities:

Quality Management: Implement an effective oversight and reporting structure for quality management. Continuously monitor and evaluate medication reconciliation, as required by The Joint Commission.

Suicide Prevention Safety Plans: Ensure clinicians develop timely, comprehensive safety plans for all patients assessed to be at high risk for suicide, and ensure the patients and/or family members receive a copy of the safety plan.

Environment of Care: Ensure that required staff attend environment of care rounds; that deficiencies identified on rounds are tracked and completed or that a plan for action is completed within 14 days of identification; that negative airflow is monitored daily in rooms used for airborne infections; and that staff identified as at risk for bloodborne pathogens exposure receive required training.

Medication Management: Consistently conduct and document appropriate actions when chronic renal disease patients' hemoglobin levels exceed 12 grams per deciliter.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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

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

Scope

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through May 17, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the*

El Paso VA Health Care System, El Paso, Texas, (Report No. 08-00137-74, February 12, 2008). The facility had corrected all findings from the previous CAP review.

During this review, we presented crime awareness briefings for 90 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the facility's Director, Chief of Staff, and QM Chief. We evaluated plans, policies, PI data, and other relevant documents.

The QM program was supported by senior managers through participation in and evaluation of PI initiatives and through allocation of resources to the program. The peer review program had a designated Peer Review Committee, and local policy was in compliance with VHA requirements. However, we identified the following areas that needed improvement.

Committee Oversight Structure. VHA policy[1] requires the facility to have a systematic approach to planning, delivering, measuring, and improving health care. The facility's QM oversight and reporting structure was fragmented and inconsistent, making it difficult to determine the extent of oversight or the corrective actions taken to improve patient care.

Although adequate data generally was collected, and trends were identified, neither the data nor the trends were consistently reported to or acted on by an appropriate

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

committee. The information collected was not always analyzed nor were actions consistently taken to improve patient care. For example, although service chiefs reported collecting and reviewing data regarding procedures, they did not send it forward to an appropriate committee for review and discussion which could have identified opportunities for improvement.

Medication Reconciliation. The JC requires health care organizations to continuously monitor medication reconciliation across the continuum of care. Patients' medications must be reviewed at key points, such as admission, transfer, and discharge, to prevent duplications, omissions, or potentially hazardous combinations. In FY 2009, facility managers did not have the required ongoing monitors for medication reconciliation to ensure compliance. Without ongoing collection of data, the facility could not monitor for trends.

Recommendations

1. We recommended that an effective oversight and reporting structure for QM be fully implemented.

2. We recommended that managers continuously monitor and evaluate medication reconciliation, as required by The JC.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional support 24 hours a day, 7 days a week.[2]

A previous OIG review of suicide prevention programs in VHA facilities[3] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not

[2] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[3] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

contain the above elements) were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings. We reviewed the medical records of nine patients assessed to be at high risk for suicide and identified the following area that needed improvement.

Safety Plans. We found that clinicians had developed safety plans for six of the nine patients whose medical records we reviewed. Of the six safety plans completed, we found that three had not been completed in a timely manner and that three did not have medical record documentation to support that the patients and/or their families received a copy of the plan.

Recommendation

3. We recommended that clinicians develop comprehensive safety plans in a timely manner for all patients assessed as being at high risk for suicide and that the patients and/or family members receive a copy of the safety plan.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

We inspected three primary and three specialty care clinics, a dental clinic, a pharmacy waiting area, the main lobby, and the ambulatory surgery clinic. The facility maintained a generally clean and safe environment. However, we identified the following areas that needed improvement.

EOC Rounds. VHA policy[4] requires the Director or Associate Director to lead weekly EOC rounds. Participants should include managers in nursing, building management, engineering, safety, patient safety, IC, and information security. We reviewed weekly EOC rounds attendance rosters and noted that rounds did not include all required participants.

Environmental Safety. The facility is required to document and track that deficiencies are corrected within 14 days or submit a plan for action. The facility documented deficiencies for FY 2009 and FY 2010 through the

[4] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.

2nd quarter. However, only 21 (33 percent) of 63 deficiencies identified were corrected within 14 days, and there were no plans for improvement submitted.

NAPR. The CDC requires daily monitoring and documentation of the negative airflow in rooms used for airborne isolation. A daily negative airflow log for one unoccupied isolation room was not maintained. When questioned, clinical staff in the primary care unit where NAPR logs were located did not know whether nursing or IC staff conducted the daily checks. Nursing staff in the primary care unit have now begun to conduct daily checks.

OSHA Bloodborne Pathogens Training. Employees at risk for exposure to bloodborne pathogens are required to complete initial and annual bloodborne pathogens training. We reviewed calendar year 2009 training records for staff from patient care areas. We found that 14 (61 percent) of 23 staff had completed the training.

Recommendation

4. We recommended that managers address the identified EOC deficiencies.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed a medication management process for outpatients.

The facility had recently implemented a practice guideline governing the maintenance of CRD patients who receive ESAs.[5] Also, although the pharmacy is only open Monday through Friday during the day, we found that the facility had appropriately provided veterans with instructions for emergency pharmacy services in the community. We identified one area that needed improvement.

Management of ESAs. In November 2007, the U.S. Food and Drug Administration issued a safety alert stating that for CRD patients, ESAs should be used to maintain hemoglobin levels between 10 and 12 g/dL. Hemoglobin levels greater than 12g/dL increase the risk of serious conditions and death. We reviewed the medical records of nine outpatients with CRD who had hemoglobin levels greater than 12g/dL. We found documentation of an action to address the hemoglobin level in three of the nine medical records.

[5] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

Recommendation

5. We recommended that clinicians consistently conduct and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

Review Activities Without Recommendations

MRI Safety

The purpose of this review was to evaluate whether the facility maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC.

The facility had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room were directly observed at all times. Two-way communication was available between the patient and the MRI technologist, and the patient had access to a push-button call system while in the scanner. Additionally, mock fire and emergency response drills had been conducted in the MRI area.

Local policy requires that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of 12 personnel and found that all had completed required safety training.

We reviewed the medical records of 10 patients who received an MRI. In all cases, patients received appropriate screening. In addition, three patients who had an MRI with contrast media had signed informed consents prior to their procedures, in accordance with local policy. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[6] We also reviewed meeting minutes during which discussions about the physicians took place.

[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the ambulatory surgery, urology, and cardiology units and the woman's clinic. We determined that the facility had appropriate policies and procedures and consistently monitored compliance with established guidelines. Also, the facility had a process in place to track RME should a sterilization failure occur.

For two pieces of RME, we reviewed the SOPs for reprocessing. In general, we found that SOPs were current and consistent with the manufacturers' instructions. Employees were able to either demonstrate the cleaning procedures in the SOPs or verbalize the steps. We reviewed the competency folders and training records of the employees who demonstrated or verbalized the cleaning procedures and found that annual competencies and training were current and consistently documented. We made no recommendations.

Comments

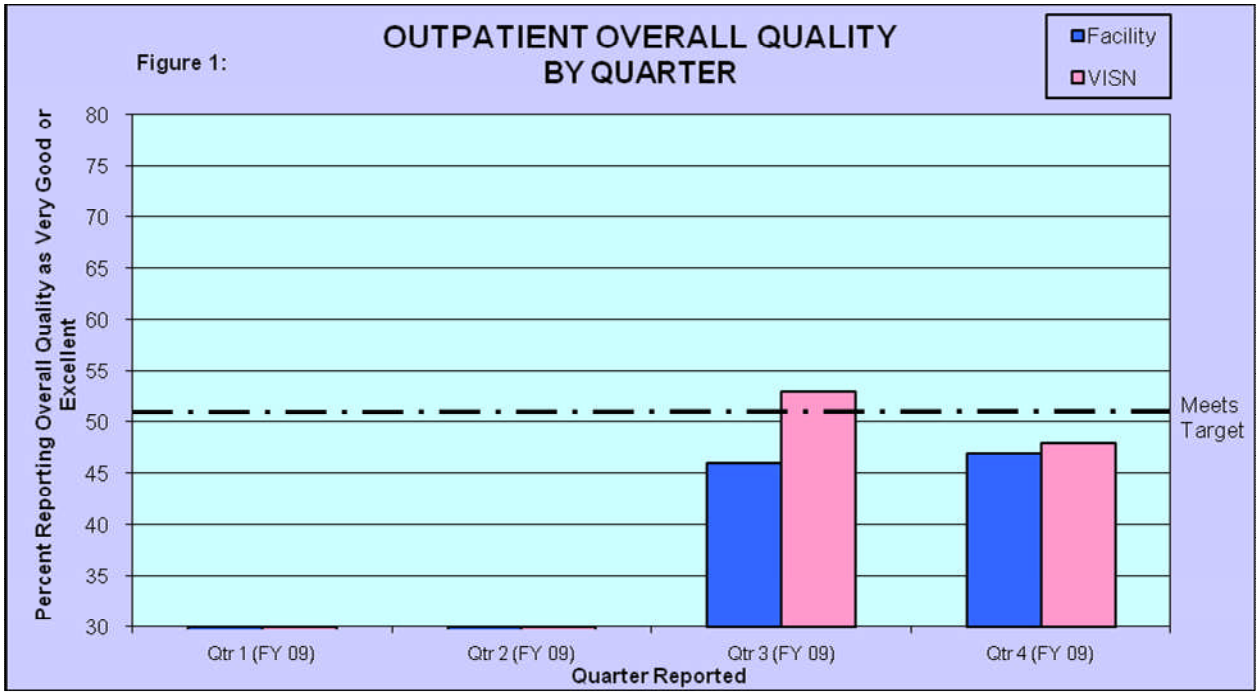
The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 11–15, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

Facility Profile[7]		
Type of Organization	Ambulatory health care system	
Complexity Level	3	
VISN	18	
CBOCs	Las Cruces, NM El Paso, TX	
Veteran Population in Catchment Area	25,000	
Type and Number of Operating Beds: • **Acute care**	N/A	
• **CLC**	N/A	
• **Other**	N/A	
Medical School Affiliation(s)	WBAMC Graduate Medical Education Training Program Texas Technical School of Medicine	
• **Number of Residents**	18	
	Current FY (2010) (through April)	**Prior FY (2009)**
Resources (in millions):		
• **Budget**	$122	$120
• **Medical Care Expenditures**	$84	$119
FTE	620	555
Workload:		
• **Number of Unique Patients**	23,532	25,344
• **Inpatient Days of Care:**		
o **Acute Care**	N/A	N/A
o **CLC**	N/A	N/A
Hospital Discharges	N/A	N/A
Total ADC (including CLC patients)	N/A	N/A
Cumulative Occupancy Rate	N/A	N/A
Outpatient Visits	185,806	270,822

[7] All data provided by facility management.

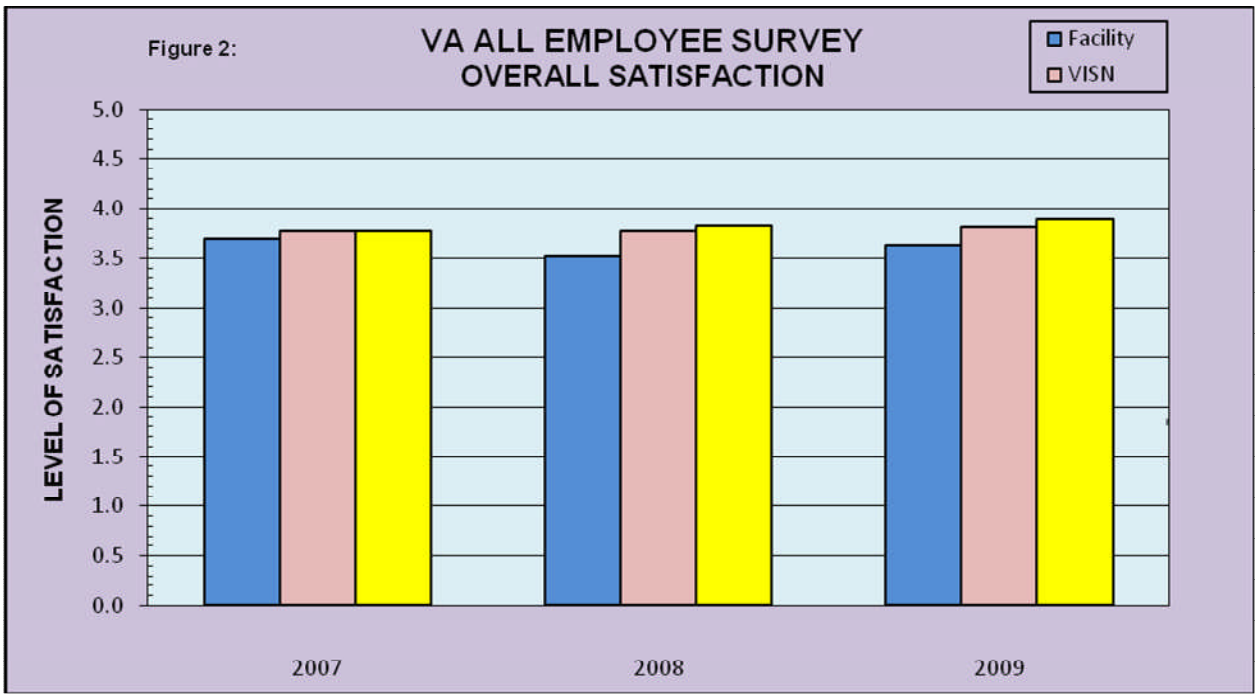
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the facility's and VISN's overall outpatient[8] satisfaction scores for quarters 3 and 4 of FY 2009.[9] The target score is noted on the graph.



[8] Inpatient overall quality is not included because this facility does not provide inpatient services.
[9] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included.

Employees are surveyed annually. Figure 2 below shows the facility's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2010

From: Network Director, VISN 18 (10N18)

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

To: Director, Dallas Healthcare Inspections Division (54DA)

Director, Management Review Service (VHA CO 10B5 Staff)

1. I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program Review of the El Paso VA Health Care System.

2. If you have additional questions or concerns, please contact Sally Compton, VISN 18 Executive Assistant to the Network Director at 602-222-2699.

(original signed by:)
Susan P. Bowers

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 13, 2010

From: Director, El Paso VA Health Care System

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

To: Network Director, VISN 18 (10N18)

1. I concur with the recommendations presented in this Combined Assessment Program (CAP) Review of the El Paso VA Health Care System during the review process from May 17, 2010 through May 21, 2010.

2. Attached are responses with action plans as appropriate for each recommendation.

3. Thank you for these opportunities for improvement. The OIG team conducted the audit in a very professional, helpful manner which made the site visit productive and educational for our staff.

4. If you have additional questions or need further information, please contact me at (915) 564-7905.

(original signed by:)
Joan Ricard, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1: We recommended that an effective oversight and reporting structure for QM be fully implemented.

Concur

Target Completion Date: February 28, 2011

The El Paso VA Health Care System's (EPVAHCS) governance structure was fully implemented in July, 2010. Education was provided during the months of June and July for board, council and committee chairs, co-chairs and administrative support. Meeting frequency is determined by each board, council and committee charter. Action tracking logs are submitted with meeting minutes to facilitate monitoring and oversight of committee activities and to ensure follow up and closure of identified action items.

Recommendation 2: We recommended that managers continuously monitor and evaluate medication reconciliation, as required by The JC.

Concur

Target Completion Date: February 28, 2011

Each clinical service area (medical, surgical, dental, and behavioral health) monitors medication reconciliation by provider as part of monthly record reviews. Records reviewed during this CAP visit revealed that Primary Care did not perform record reviews for several months.

Retrospective reviews are being conducted by Primary Care for the months that the reviews were not completed. In addition, a process will be implemented by the Medical Records Review Committee, which was re-chartered in June, 2010, to ensure ongoing record reviews comply with the JC requirements.

Recommendation 3: We recommended that clinicians develop comprehensive safety plans in a timely manner for all patients assessed as being at high risk for suicide and that the patients and/or family members receive a copy of the safety plan.

Concur

Target Completion Date: February 28, 2011

Safety Plans**.** The Center Policy Memorandum, CPM 116-21 Patient Record Flags, previously stated *"A Suicide Prevention Safety Plan must be completed with the patient immediately by the provider that recognized the risk."* CPM 116-21 was revised in June 2010 to state *"A Suicide Prevention Safety Plan must be completed in corroboration with the patient as soon as is reasonable taking into consideration the clinical situation and the availability of the patient. It is desirable to complete the Safety Plan at the time the Veteran is assessed to be at high risk. Every effort should be made to complete the plan for a hospitalized Veteran before he/she is discharged from the hospital."*

Additionally, the suicide prevention safety plan is a templated note and is being revised to include an acknowledgement for the patient and/or family member to sign, validating their receipt of a copy of the safety plan.

Recommendation 4: We recommended that managers address the identified EOC deficiencies.

Concur

Target Completion Date: February 28, 2011

EOC Rounds. The policy for EOC rounds is being revised to include required participants in accordance with VHA policy.

Environmental Safety. The policy for environmental safety was amended in May 2010 and requires the service responsible for corrective action to correct each deficiency within 14 days or submit an action plan in accordance with VHA monitor guidelines. A Rounds Monitoring Tool to track deficiencies, the number of deficiencies corrected in 14 days, and plans for action will track and trend deficiency correction timeliness. Outstanding deficiencies and/or action plans will be escalated up the chain of command to the Executive Leadership Team (ELT) if not corrected/submitted within ten days. Follow-up evaluations will be made on subsequent inspections to validate corrective actions.

NAPR. Local policy is being revised to reflect monitoring and documentation of negative airflow rooms in accordance with Center for Disease Control (CDC) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities, 2005.

OSHA Bloodborne Pathogens Training. Local requirements were revised by the Infection Control Committee, August 2010, which recommended all employees complete annual bloodborne pathogen training. This recommendation has been submitted for approval through the governance structure referral process. Approval is expected to be finalized by September 30, 2010.

Recommendation 5. We recommended that clinicians consistently conduct and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

Concur

Target Completion Date: February 28, 2011

Management of ESAs. Policy and treatment guidelines have been established requiring the clinical pharmacist to review all ESA prescriptions for appropriateness, monitor hemoglobin levels and adjust ESA dosage per treatment guidelines.

OIG Contact and Staff Acknowledgments

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