Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03076-65

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

December 20, 2012

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

CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	West Texas VA Health Care System
FY	fiscal year
HF	heart failure
MH	mental health
MM	medication management
OIG	Office of Inspector General
PACT	Patient Aligned Care Team
PI	performance improvement
PMR	physical medicine and rehabilitation
POCT	point-of-care testing
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, TX

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 September 24, 2012.

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

- Continuity of Care
- Coordination of Care
- Environment of Care
- Medication Management

The facility's reported accomplishments were the Patient Aligned Care Team Telehealth Pharmacy Services Program and the Nurse Triage Call Center.

Recommendations: We made recommendations in the following five activities:

Moderate Sedation: Ensure that pre-sedation assessment documentation includes all required elements and that providers re-evaluate patients immediately prior to sedation.

Point-of-Care Testing: Ensure employees who perform glucose point-of-care testing have competency assessed at the required intervals. Delineate all actions to be taken in response to critical results. Notify clinicians of critical test results requiring follow-up. Ensure staff complete the actions required in response to critical test results, and document the actions taken.

Colorectal Cancer Screening: Ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Polytrauma: Ensure that patients with positive traumatic brain injury screening results receive a comprehensive evaluation as outlined in Veterans Health Administration policy.

Quality Management: Ensure the Electronic Health Record Committee provides consistent oversight and coordination of electronic health record quality reviews, and analyze and trend electronic health record quality reviews.

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.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

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

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 nine activities:

- Continuity of Care
- Coordination of Care
- CRC Screening
- EOC
- MM
- Moderate Sedation
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through September 24, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas,* Report No. 11-02079-287, September 21, 2011).

During this review, we presented crime awareness briefings for 41 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 108 responded. We shared survey results with facility managers.

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.

Reported Accomplishments

PACT Telehealth Pharmacy Services Program

In FY 2012, the Pharmacy Service leveraged the technology of the facility's award-winning Anticoagulation Telehealth Program and implemented the PACT Telehealth Pharmacy Services Program. The program has improved performance measure scores, increased efficiency of the clinics, and increased reimbursement rates from third party insurance and aligns with VA's national goals of PACT implementation.

The program exemplifies innovation by taking a different approach to PACT implementation via new patient appointments and MM appointments. It has streamlined the ordering of medications and laboratory tests through new patient appointments. Clinical pharmacists conduct new patient appointments several weeks prior to the initial provider visit. During the visit, all medications are converted to formulary, and laboratory tests are ordered. The medication ordering process saves the provider 20 to 30 minutes per new patient visit. The MM appointments target high-risk patients who are falling out of performance measure parameters for conditions such as hyperlipidemia, diabetes, and hypertension. There have been significant improvements in performance measure scores for patients seen in these clinics.

Nurse Triage Call Center

The Nurse Triage Call Center was established in 2010 to provide 24-hour access to nurse advice and assistance. The overwhelming local success prompted the call center's expansion. In 2011, the call center began providing service for all of VISN 18.

Initially, the call center experienced a dropped call rate that averaged between 20 and 30 percent, and the average speed to answer a call was between 75 and 90 seconds. Tremendous progress since that time has led to a current dropped call rate of just over 5 percent, with a target of below 5 percent, and the average speed to answer a call is less than 20 seconds, with a target of below 30 seconds. The facility took a multi-faceted approach to accomplish their goals. They analyzed trends in peak call times and altered staffing to accommodate such times, installed new technology allowing the nurses to see all the calls in the queue, increased staff awareness of goals, and measured progress.

Results
Review Activities With Recommendations

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 10 EHRs, and 3 training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[1] VHA also requires that patients be re-evaluated immediately before moderate sedation. None of the patients' EHRs included all required elements of the history and physical examination, such as substance use, time and nature of last oral intake, and any previous adverse experience with sedation or analgesia. Additionally, three patients' EHRs did not include documented evidence of patient re-evaluation immediately prior to sedation.

Recommendation

1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements and that providers re-evaluate patients immediately prior to sedation.

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 28 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed a physical inspection of one patient care area where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
X	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
X	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Competency Assessment. VHA requires the facility to complete and document competency assessments for all employees who perform glucose POCT.[2] The College of American Pathologists requires that after successful initial competency assessment, employees must have competency reassessed in 6 months. All employees who perform glucose POCT must then have competency assessed annually.

One of the two new employee training and competency records reviewed did not contain documented evidence of competency assessment and reassessment at the required intervals. Additionally, none of the 10 applicable employee training and competency records had documented evidence of annual competency assessment.

[2] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

Test Results Management. VHA requires that facilities delineate actions to be taken in response to critical results and that critical results requiring follow-up be communicated to the responsible clinician to ensure that appropriate and prompt actions are taken if indicated.[3] Although it was standard practice on the inpatient unit for the nurse to repeat the glucose test in response to critical results, facility policy did not delineate this. In addition, for three of the eight patients who had critical test results, there was no documented evidence of clinician notification.

When glucose values are determined to be critical, the facility requires the employee performing the test to obtain clinical laboratory verification and document using a Critical Lab Readback Note title. Of the eight EHRs of patients who had critical test results, four did not have clinical laboratory verification, and four did not have a Critical Lab Readback Note.

Recommendations

2. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have competency assessed at the required intervals.

3. We recommended that the facility delineate all actions to be taken in response to critical results and that processes be strengthened to ensure that clinicians are notified of critical test results requiring follow-up.

4. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results and document the actions taken and that compliance be monitored.

[3] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[4] Of the three patients who had a biopsy, two EHRs did not contain documented evidence of timely notification.

Recommendation

5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[4] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of outpatients with positive TBI results, and 3 training records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
X	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results at a Level IV site be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[5] A higher level Polytrauma System of Care site must complete the comprehensive evaluation, or a Level IV site can develop and submit an alternate plan for review by the VISN and the national Director of PMR for approval of alternate arrangements outside of the directive.

Of the 10 outpatients who screened positive for TBI, 2 refused a comprehensive TBI evaluation. The remaining eight patients received the comprehensive evaluation at the facility and were not referred to a higher level Polytrauma System of Care site. The facility did not have an alternate plan approved by the VISN and the national Director of PMR during the timeframe of our review.

[5] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans,* March 8, 2010.

Recommendation

6. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/PI improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
X	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed (continued)
	Overall, there was evidence that senior managers were involved in PI over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/PI improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

EHR Review. VHA requires facilities to have an EHR Committee that provides oversight of EHR quality reviews, which includes analyzing aggregated data.[6] We found that the EHR Committee provided inconsistent oversight and coordination and did not analyze or trend aggregated data.

Recommendation

7. We recommended that processes be strengthened to ensure that the EHR Committee provides consistent oversight and coordination of EHR quality reviews and that EHR quality reviews are analyzed and trended.

[6] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Review Activities Without Recommendations

Continuity of Care

The purpose of this review was to evaluate whether communication between facility primary care and community hospitals occurred when facility patients were hospitalized in the community at VA expense. Such communication is essential to continuity of care and optimal patient outcomes.

We reviewed the EHRs of 30 patients who were hospitalized at VA expense in the local community from September 2011 to September 2012. We assessed whether documentation of community hospitalization was available to the PACT for the clinic visit subsequent to the hospitalization. In addition, we looked for evidence to determine whether the PACT acknowledged and documented the community hospitalization in patient EHRs. The facility generally met requirements in these areas. We made no recommendations.

Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 13 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's domiciliary was in compliance with selected MH RRTP requirements.

We inspected the CLC, the domiciliary, and five outpatient clinics (dental, PMR, primary care, SCI, and urgent care). Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or SCI outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe MM, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.

Noncompliant	Areas Reviewed for MH RRTP (continued)
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

MM

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[7] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[7] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

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 19–23, for the full text of the Directors' comments. We will follow up on the planned actions until they are completed.

Facility Profile[8]		
Type of Organization	Medical center	
Complexity Level	3	
VISN	18	
Community Based Outpatient Clinics	Abilene, TX Odessa, TX San Angelo, TX Hobbs, NM Fort Stockton, TX (outreach clinic) Stamford, TX (outreach clinic)	
Veteran Population in Catchment Area	55,926	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	60	
• **CLC/Nursing Home Care Unit**	40	
• **Other**	0	
Medical School Affiliation(s)	Texas Tech University	
• **Number of Residents**	5	
	Current FY (through May 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$101.5	$98.1
• **Medical Care Expenditures**	$64.3	$76.7
Total Medical Care Full-Time Employee Equivalents	247	553
Workload:		
• **Number of Station Level Unique Patients**	15,186	17,061
• **Inpatient Days of Care:**		
o **Acute Care**	0	613
o **CLC/Nursing Home Care Unit**	7,880	10,511
Hospital Discharges	220	493
Total Average Daily Census (including all bed types)	61	45
Cumulative Occupancy Rate (in percent)	61	45
Outpatient Visits	106,058	150,992

[8] 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. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

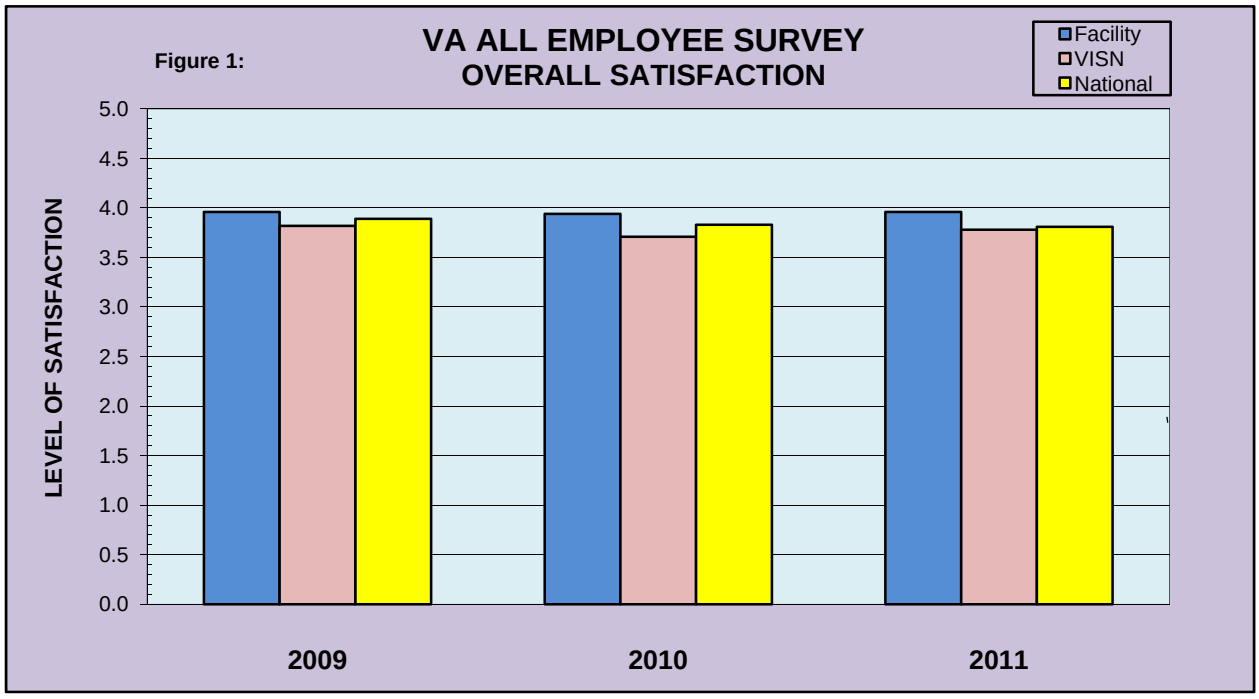
Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	*	*	41.7	55.5	45.4	48.0
VISN	63.8	67.3	51.0	53.7	51.1	52.5
VHA	64.1	63.9	54.2	54.5	55.0	54.7

* A score is not reported because there were fewer than 30 cases.

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[9] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[10]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	*	11.3	11.3	*	25.4	18.4
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

* No data is available from the facility for this measure.

[9] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[10] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 20, 2012

From: Director, VA Southwest Health Care Network (10N18)

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

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

I concur with the recommendations for improvement contained in the Draft Combined Assessment Program review at the West Texas VA Health Care System. If you have any questions or concerns, please contact Sally Compton, Executive Assistant to the Network Director, VISN 18, at 602-222-2699.

Susan P. Bowers
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 16, 2012

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

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

To: Director, VA Southwest Health Care Network (10N18)

1. I take this opportunity to thank the Office of Inspector General Combined Assessment Program (CAP) Survey Team for a professional, comprehensive, impartial and educational survey conducted September 24–27, 2012. I appreciate the opportunity to provide comments to the report of the OIG CAP review of the West Texas VA Health Care System (WTVAHCS). I concur with the findings and the recommendations for improvement. The WTVAHCS staff have already begun corrective actions on all recommendations.

2. The WTVAHCS staff are pleased with the results and improvements that resulted from the survey findings. The collaborative efforts of the experts on the CAP review team have contributed to improvements in the level of care, safety and services that WTVAHCS provides our Veterans.

Daniel L. Marsh
Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements and that providers re-evaluate patients immediately prior to sedation.

Concur

Target date for completion: November 30, 2012

The history and physical pre-operative note template will be modified to include all required elements (including history and/or previous complications with sedation; date/time of last intake for both liquids and solids; and, history of substance use), and verification that providers re-evaluate patients immediately prior to sedation. Compliance data will be monitored on 50 records per quarter until 100% compliance is achieved. Results will be reported by Quality Management during monthly Operative and Invasive Procedure Subcommittee meetings.

Recommendation 2. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have competency assessed at the required intervals.

Concur

Target date for completion: December 31, 2012

All nurse glucose competencies were completed in September 2012. Retesting of competencies is scheduled for March 2013. Competencies will be accomplished during initial orientation, six months later and on an annual basis each September as required by the College of American Pathologists. Nurse Executive/designee will review 6-part competency folders to monitor compliance and report to Quality Executive Board on a semi-annual basis.

Recommendation 3. We recommended that the facility delineate all actions to be taken in response to critical results and that processes be strengthened to ensure that clinicians are notified of critical test results requiring follow-up.

Concur

Target date for completion: January 31, 2013

The standard operating procedure has been amended to reflect current practice which includes a second glucose check when a glucose reading is abnormal. When a second check confirms an abnormal result, the nurse contacts the physician for treatment orders. The Assistant Nurse Manager will monitor compliance with the operating procedure on a weekly basis until 100% compliance is achieved for three consecutive months and report to the Quality Executive Board.

Recommendation 4. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results and document the actions taken and that compliance be monitored.

Concur

Target date for completion: December 21, 2012

The standard operating procedure will be amended to require the use of a critical lab read back note template. The note entered by nursing will indicate the laboratory person reporting the critical value, which provider was notified and the actions taken to correct the critical value. The CLC Nurse Manager will monitor compliance with the procedure. The CLC Nurse Manager will report compliance monthly to Quality Executive Board until 90% compliance is met for three consecutive months.

Recommendation 5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: December 14, 2012

Consult management will generate a view alert to Patient Aligned Care Team (PACT) upon receipt of biopsy results. All negative or normal results will be communicated within 14 days either by mail or phone call to the Veteran. Veterans with positive results will be notified by their PCP either by telephone or face-to-face appointment to convey the results within 14 days. Compliance to the process will be monitored by the Chief of Staff (COS) through record reviews and reported to the Medical Executive Board quarterly until 90% compliance is achieved for three consecutive months.

Recommendation 6. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Concur

Target date for completion: December 28, 2012

The Polytrauma provider's workload/clinic profile will be reviewed and adjusted to give additional time for all aspects of completion of this evaluation in accordance with

alternative plan. Case Management Tracking Application (CMTRA) Outlier suspense is reported to the VISN monthly to ensure timely contacts are made. The COS will establish an interdisciplinary rehabilitation team to develop treatment plans that include all required elements.

Recommendation 7. We recommended that processes be strengthened to ensure that the EHR Committee provides consistent oversight and coordination of EHR quality reviews and that EHR quality reviews are analyzed and trended.

Concur

Target date for completion: December 31, 2012

Medical Records Review Committee (MRRC) charter and membership will be updated and approved through Medical Executive Board by Leadership Council. Each MRRC member will designate a specific and consistent alternate to attend when primary member cannot attend. A consistent alternate for primary members will provide oversight and coordination of EHR quality reviews.

MRRC will be chaired by Chief, Health Information Management Service (HIMS) and co-chaired by the Records Management Coordinator. The COS will be added as a reviewing official for MRRC minutes. The MRRC agenda will be updated in accordance with requirements outlined in VHA Handbook 1907, Health Information Management and Health Records, to ensure that EHR quality reviews are analyzed and trended. Results will be monitored by the Medical Executive Board quarterly.

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