Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00108-274

Combined Assessment Program Review of the Tuscaloosa VA Medical Center Tuscaloosa, Alabama

April 28, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Tuscaloosa VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. We conducted the review the week of February 1, 2016.

Review Results: The review covered seven activities and two follow-up review areas from the previous Combined Assessment Program review. We made no recommendations in the following three activities:

- Coordination of Care
- Advance Directives
- Environment of Care

The facility's reported accomplishment was an enhanced use lease to provide housing for homeless veterans.

Recommendations: We made recommendations in the following four activities and two follow-up review areas:

Quality, Safety, and Value: Ensure Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.

Medication Management: Annually assess the competency of pharmacy employees who prepare compounded sterile products. Perform and document monthly cleaning of storage shelving in all compounding areas.

Computed Tomography Radiation Monitoring: Revise the radiation safety policy to include required elements. Confirm computed tomography technologists have computed tomography certification prior to hiring them, and ensure all current technologists hired after July 1, 2014, have the certification.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within the required timeframe. Consistently place flags in the electronic health records of high-risk patients.

Follow-Up on Quality Management: Ensure Focused Professional Practice Evaluations for newly hired licensed independent practitioners are reported timely to the Medical Executive Committee.

Follow-Up on Environment of Care: Ensure Sterile Processing Service employees responsible for reprocessing activities receive annual competency assessments.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–30, for the full text of the Directors' comments.) We consider recommendations 2 and 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objective and Scope

Objective

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 objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities and two follow-up review areas from the previous CAP review:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- Follow-Up on Quality Management
- Follow-Up on EOC

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2014, FY 2015, and FY 2016 through February 1, 2016, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide

the status on the recommendations we made in our previous CAP report *Combined Assessment Program Review of the Tuscaloosa VA Medical Center, Tuscaloosa, Alabama,* Report No. 13-01673-240, July 11, 2013). We made repeat recommendations in Quality Management and EOC.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 130 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Homeless Housing Enhanced Use Lease

The facility established a partnership with a private entity through an enhanced use lease to provide housing for homeless veterans. The final enhanced use lease agreement was signed on August 14, 2013, and a VA Capital Contribution of $4 million was secured to assist with environmental remediation issues during renovation of an existing vacant historic building on the facility's campus. The developer secured the remaining financing for construction of 50 apartments that provide housing for homeless veterans and their families through other mechanisms, including private equity and low-income housing tax credits. In addition, the project was awarded 50 project-based Department of Housing and Urban Development-VA Supportive Housing vouchers to provide rental assistance. The developer serves as the independent management company of the housing complex. The project officially began construction on October 1, 2013, and a grand opening was held on November 10, 2014, making it one of the first homeless housing enhanced use lease projects to open on a VA campus.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a FPPE for cause would be indicated. • The facility followed its policy when employees' licenses expired.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.	• For 35 of the 48 cases (73 percent) referred to Physician Utilization Management Advisors December 1, 2015–January 31, 2015, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database.	**1.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in the dental clinic.[b]

We inspected four community living centers, two MH inpatient units, an MH Residential Rehabilitation Treatment Program, two primary care clinics, an MH outpatient clinic, a minute clinic, and a women's clinic. Additionally, we reviewed relevant documents and all six dental clinic employees' training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for the OR	Findings	Recommendations
NA	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
NA	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
NA	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
NA	The facility monitored OR temperature, humidity, and positive pressure.		
NA	The facility met fire safety requirements in the OR.		
NA	The facility met environmental safety requirements in the OR.		
NA	The facility met infection prevention requirements in the OR.		
NA	The facility met medication safety and security requirements in the OR.		
NA	The facility met laser safety requirements in the OR.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees (5 pharmacists and 5 technicians). Additionally, we inspected one area where sterile products are compounded. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
X	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.	• Pharmacy employees who prepared CSPs did not have annual competency assessment.	**2.** We recommended that the facility annually assess the competency of pharmacy employees who prepare compounded sterile products and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
NA	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
NA	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
NA	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
NA	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
X	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.	• There was no documented evidence of monthly cleaning of storage shelving in the compounding areas.	**3.** We recommended that facility managers ensure employees perform and document monthly cleaning of storage shelving in all compounding areas and monitor compliance.
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.		
	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision		
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patient and/or caregiver understanding.		
	The facility complied with any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for four CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
X	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans	• The facility's radiation safety policy did not include: o A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance o CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer o A process for managing/reviewing CT protocols and procedures to follow when revising protocols o Radiologist review of appropriateness of CT orders	**4.** We recommended that the facility revise the radiation safety policy to include a computed tomography quality control program with annual program monitoring by a medical physicist, image quality monitoring, and scanner maintenance; computed tomography protocol monitoring and a method for identifying and reporting excessive doses to the Radiation Safety Officer; a process for managing/reviewing computed tomography protocols and procedures to follow when revising protocols; and radiologist review of appropriateness of computed tomography orders.

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
X	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.	• One CT technologist hired after July 1, 2014, did not have CT certification.	**5.** We recommended that facility managers confirm computed tomography technologists have computed tomography certification prior to hiring them and ensure all current computed tomography technologists hired after July 1, 2014, have the certification.
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
NA	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.		
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period October 1, 2014–September 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Four of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**6.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.	• Clinicians had not placed flags in the EHRs of 2 of 19 high-risk patients.	**7.** We recommended that clinicians consistently place flags in the electronic health records of high-risk patients and that facility managers monitor compliance.
	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe		
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge • Every 90 days to review Patient Record Flags		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activities With Previous CAP Recommendations

Follow-Up on Quality Management

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with FPPEs.[h]

FPPEs. VHA requires an FPPE for all new privileges granted. FPPEs are required for practitioners new to the facility and those requesting new privileges. In our previous review, we found that FPPEs were not reported to the Medical Executive Committee in a timely manner. During this review, the facility reported only partial compliance with ensuring FPPEs for newly hired licensed independent practitioners were reported timely to the Medical Executive Committee.

Recommendation

8. We recommended that facility managers ensure Focused Professional Practice Evaluations for newly hired licensed independent practitioners are reported timely to the Medical Executive Committee.

Follow-Up on EOC

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with reusable medical equipment competency assessments.[i]

Reusable Medical Equipment Competency Assessments. VHA requires Sterile Processing Service employees to have annual training on cleaning and maintaining reusable medical equipment. During our previous review, we found that none of the employees had completed the required annual competency assessments. During this review, we examined the competency records of all Sterile Processing Service employees responsible for reprocessing activities and found that none of the three had completed, documented annual competency assessments for the 2 prior years.

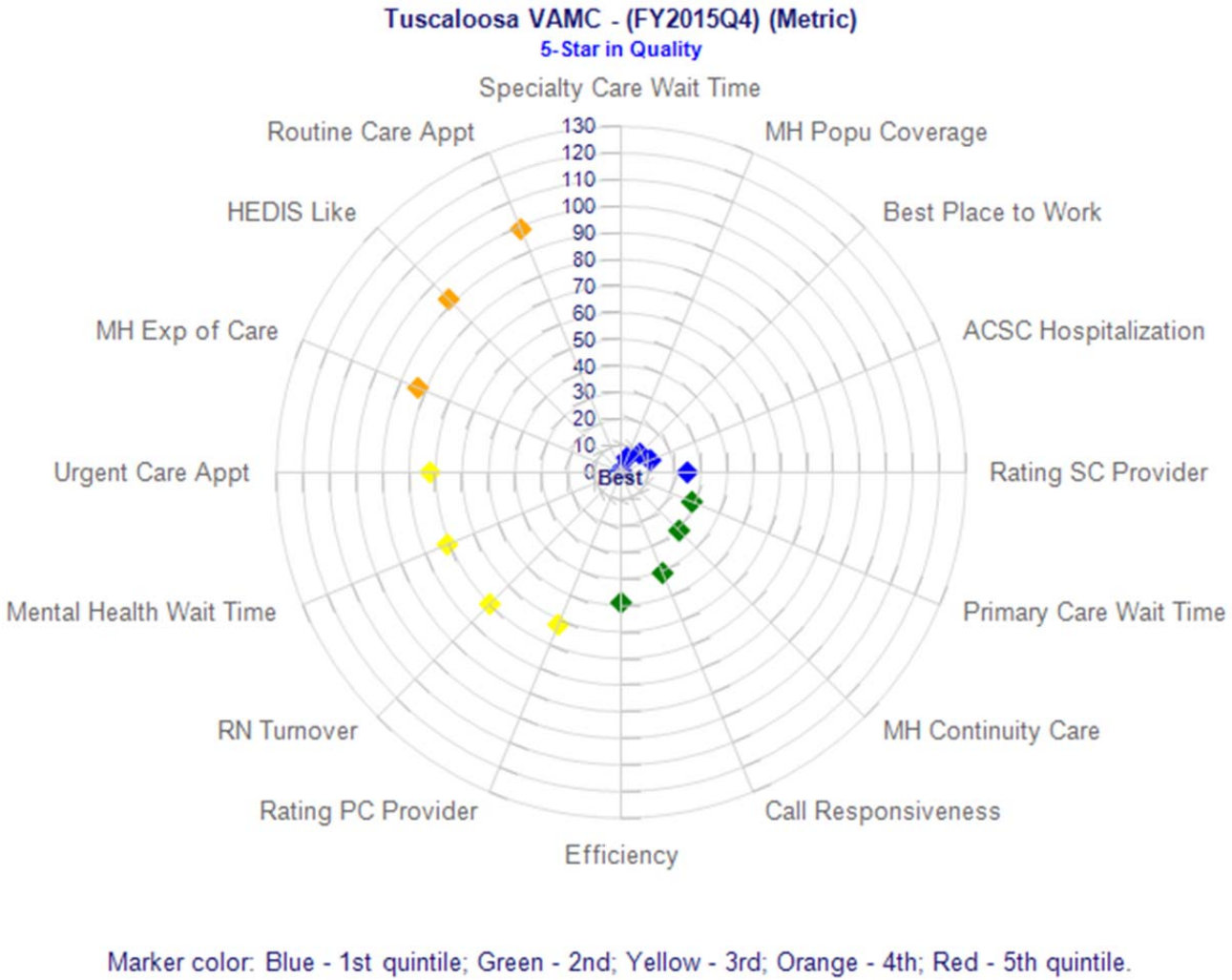
Recommendation

9. We recommended that facility managers ensure Sterile Processing Service employees responsible for reprocessing activities receive annual competency assessments.

Facility Profile (Tuscaloosa/679) FY 2016 through February 2016[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$47
Number of:	
• **Unique Patients**	12,378
• **Outpatient Visits**	74,812
• **Unique Employees**[2]	781
Type and Number of Operating Beds (as of January 2016):	
• **Hospital**	87
• **Community Living Center**	104
• **Domiciliary**	84
Average Daily Census (as of January 2016):	
• **Hospital**	54
• **Community Living Center**	101
• **Domiciliary**	64
Number of Community Based Outpatient Clinics	1
Location(s)/Station Number(s)	Selma/679GA
Veterans Integrated Service Network Number	7

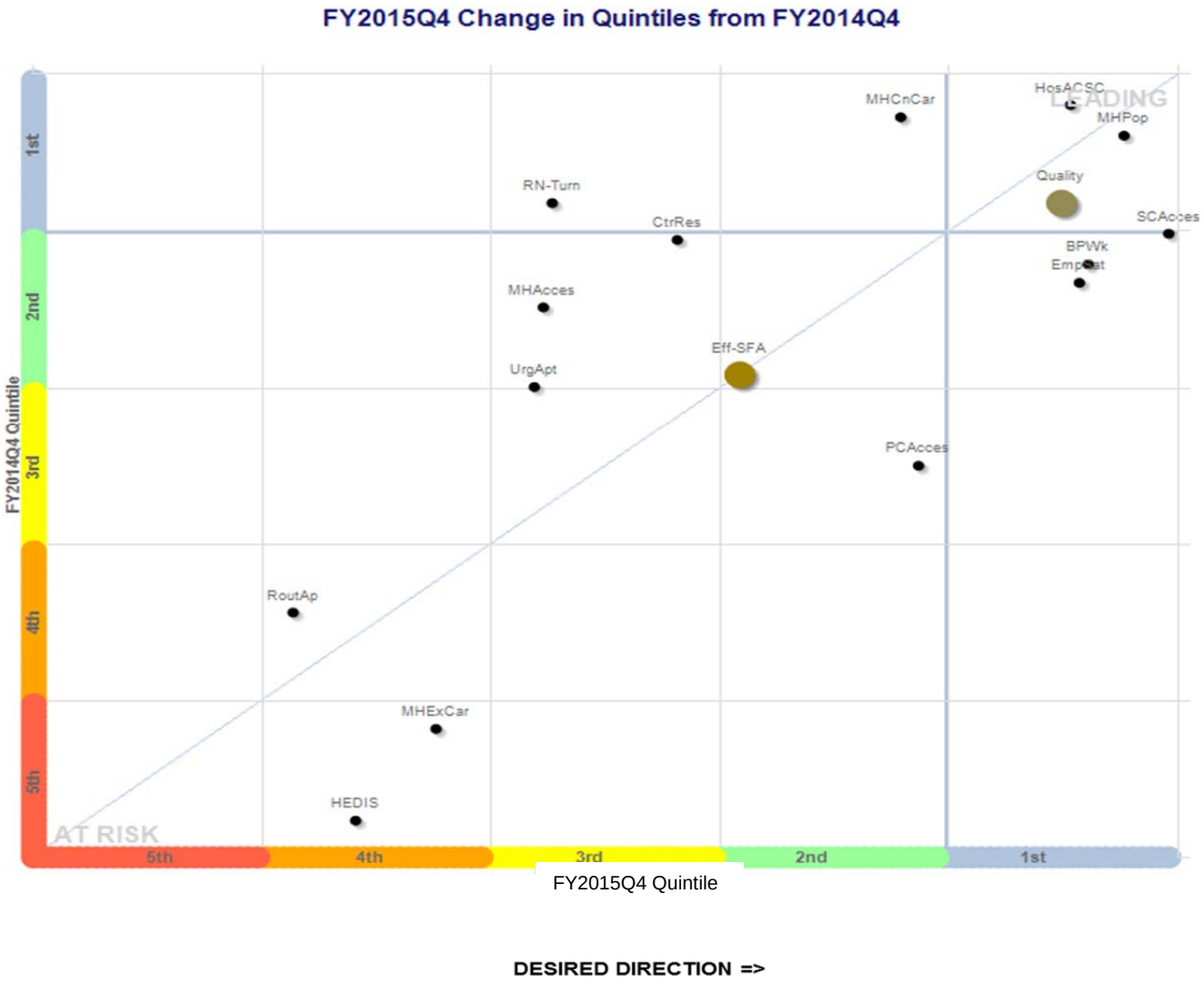
[1] All data is for FY 2016 through February 2016 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

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
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
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	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
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
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	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
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-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-CHF	30-day risk standardized readmission rate for congestive heart failure	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
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 and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 30, 2016

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Tuscaloosa VA Medical Center, Tuscaloosa, AL**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. Thank you for the opportunity to review the draft report of OIG Combined Assessment Program Review – Tuscaloosa.
2. I concur with the report and recommendations. Attached is the facility's corrective action plan for cited recommendations.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact Donna Schnider, VISN 7 Quality Management Officer, at 678-924-5700.

Director, VA Southeast Network (10N7)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 11, 2016

From: Director, Tuscaloosa VA Medical Center (679/00)

Subject: **CAP Review of the Tuscaloosa VA Medical Center, Tuscaloosa, AL**

To: Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review the draft Tuscaloosa VA Medical Center Combined Assessment Program report.

2. I concur with the report and recommendations. Attached is the facility's corrective action plan for recommendations 1 through 9.

3. If you have additional questions or need further information, please contact me at (205) 554-2000 ext. 2201.

John F. Merkle, FACHE

Director, Tuscaloosa VA Medical Center (679/00)

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 Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: July 30, 2016

Facility response: A total of three Physician Utilization Management Advisors [PUMA] have completed training as of February 25, 2016 on how to document in the National Utilization Management Integrated [NUMI] data base. They have been given the link to the NUMI data base to document their decisions. Audits will be conducted monthly to monitor for consistency of PUMA documentation until 90% or greater compliance is achieved for 3 consecutive months. Compliance regarding the PUMA documentation in NUMI will be included in the quarterly Utilization Management report and disseminated for leadership review routinely.

Recommendation 2. We recommended that the facility annually assess the competency of pharmacy employees who prepare compounded sterile products and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: A competency checklist was developed regarding preparation of compound sterile products. 100% of all the pharmacy personnel involved in sterile products preparation have been trained and their competency binders have been updated appropriately. Compliance will be monitored annually by the Pharmacy Chief.

Recommendation 3. We recommended that facility managers ensure employees perform and document monthly cleaning of storage shelving in all compounding areas and monitor compliance.

Concur

Target date for completion: July 30, 2016

Facility response: The cleaning check list was updated to include documentation of shelf cleaning. The employees will conduct cleaning of the storage shelving monthly.

Audits of shelves cleaning will be conducted monthly by the Pharmacy Chief or designee until 90% or greater compliance is achieved. Once 90% compliance is achieved, quarterly audits will be done.

Recommendation 4. We recommended that the facility revise the radiation safety policy to include a computed tomography quality control program with annual program monitoring by a medical physicist, image quality monitoring, and scanner maintenance; computed tomography protocol monitoring and a method for identifying and reporting excessive doses to the Radiation Safety Officer; a process for managing/reviewing computed tomography protocols and procedures to follow when revising protocols; and radiologist review of appropriateness of computed tomography orders.

Concur

Target date for completion: April 30, 2016

Facility response: The Radiation Safety Program policy was revised to include required elements (a computed tomography quality control program with annual program monitoring by a medical physicist, image quality monitoring, and scanner maintenance: computed tomography protocol monitoring and a method for identifying and reporting excessive doses to the Radiation Safety Officer; a process to managing/reviewing computed tomography protocols and procedures to follow when revising protocols; and radiologist review of appropriateness of computed tomography orders) and is under review for approval with expected completion by April 2016.

Recommendation 5. We recommended that facility managers confirm computed tomography technologists have computed tomography certification prior to hiring them and ensure all current computed tomography technologists hired after July 1, 2014, have the certification.

Concur

Target date for completion: February 14, 2016

Facility response: There is one primary certified CT technologist and two grandfathered CT technologist serving as back-up in the absence of the primary CT technologist. The facility has one technologist hired after July 1, 2014 who does not have CT certification and no longer performs computed tomography. The facility will ensure CT technologists are certified prior to hire.

Recommendation 6. We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Suicide Prevention Coordinator (SPC) created a Suicide Prevention Education tracking spreadsheet to monitor completion of the SAVE training and Suicide Risk Management Training requirements for new clinical employees. The SPC will work in collaboration with the Education Program Specialist to determine all newly hired clinicians. Compliance will be monitored monthly until 90% or greater compliance achieved for two consecutive quarters. Quarterly reports will be provided to the Mental Health Staff Meeting for leadership oversight.

Recommendation 7. We recommended that clinicians consistently place flags in the electronic health records of high-risk patients and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Suicide Prevention Coordinator is scheduled to provide refresher training to clinicians regarding local Patient Record Flag policy, emphasizing the importance of Suicide Risk Assessments and identifying patients who are at high risk of suicide by May 30, 2016 as evidence by signed verification of training. Compliance will be monitored through chart reviews on individuals who are at high risk for suicide. Audits will be conducted monthly until 90% or greater compliance is achieved for 3 consecutive months after which quarterly audits will be conducted by the SPC and reported in Mental Health Staff Meeting.

Recommendation 8. We recommended that facility managers ensure Focused Professional Practice Evaluations for newly hired licensed independent practitioners are reported timely to the Medical Executive Committee.

Concur

Target date for completion: December 31, 2016

Facility response: Education will be provided to designated individuals regarding the Focused Professional Practice Evaluation (FPPE) process according to the Medical Staff by-laws prior to May 30, 2016 with verification by signed receipt of training. All FPPE for newly hired licensed independent practitioners will be monitored and tracked for timeliness using the FPPE tracking form. Audits will be conducted by the Chief of Staff/designee until 90% or greater compliance is achieved for two consecutive quarters and reported to the Performance Measurement Oversight Committee.

Recommendation 9. We recommended that facility managers ensure Sterile Processing Service employees responsible for reprocessing activities receive annual competency assessments.

Concur

Target date for completion: September 30, 2016

Facility response: Competencies were updated for all Sterile Processing Service employees in January, 2016 prior to OIG site visit. The Associate Chief Nurse, Operations consulted Quality Management and the Education Department and reviewed competency checklists as a follow up. A risk assessment will be conducted to determine annual competencies with development of a routine schedule by May 30, 2016. Random audits will be conducted by the Education Department and/or Quality Management annually to monitor compliance.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Cathleen King, MHA, CRRN, Team Leader Shelia Farrington-Sherrod, RN, MSN Rose Griggs, MSW, LCSW Gayle Karamanos, MS, PA-C Trina Rollins, MS, PA-C
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Roneisha Charles, BS Lin Clegg, PhD Marnette Dhooghe, MS Larry Ross, Jr., MS Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Southeast Network (10N7)
Director, Tuscaloosa VA Medical Center (679/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeff Sessions, Richard C. Shelby
U.S. House of Representatives: Robert Aderholt, Mo Brooks, Bradley Byrne, Gary Palmer, Martha Roby, Mike Rogers, Terri A. Sewell

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

Endnotes

[a] The References used for this topic 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 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] The references used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] The references used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] The references used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.

[h] The reference used for this topic was:
- VHA Handbook 1100.09, *Credentialing and Privileging*, October 15, 2012.

[i] The reference used for this topic was:
- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health administration Facilities*, February 9, 2009.