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OFFICE OF INSPECTOR GENERAL

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VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System
Harlingen, Texas

CHIP REPORT | REPORT #19-00035-247 | OCTOBER 23, 2019

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Figure 1. *VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas (Source: https://vaww.va.gov/directory/guide/, accessed on May 30, 2019)*

Abbreviations

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

Report Overview

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

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

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

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

This unannounced visit was conducted during the week of May 6, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and

[1] The OIG's review of the emergency department and urgent care center (UCC) operations and management focused on the clinical risks of the emergency department/UCC areas. This review was not performed at the VA Texas Valley Coastal Bend Health Care System because the facility did not have an emergency department or UCC.

other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Joint Leadership Council having oversight for several working groups. The director and chief of Quality Management were co-chairs of the Quality Executive Board, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The facility leaders had been working together for approximately nine months. Of note, each member of the leadership team served in other roles at the facility prior to being permanently assigned an executive leadership position.

The OIG noted that selected employee satisfaction survey results indicated that employees seem generally satisfied with facility leaders, but the director appears to have an opportunity to promote a culture of safety and ensure employees are aware of resources available to help when unsure of the correct course of action. For the two patient experience survey scores applicable to the facility, one survey question was lower than the VHA average while the other was higher than the VHA average. In addition, facility leaders appeared to be actively engaged with patients, for example, through the interaction with patients during leadership rounding and implementation of a centralized call system, which included a telephone nurse triage process.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] and disclosures of adverse patient events and did not identify any substantial organizational risk factors.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is a way to "understand the similarities

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

and differences between the top and bottom performers" within VHA.[3] Although the leadership team members were generally knowledgeable within their areas of responsibility about selected SAIL metrics, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "2-star" quality ratings.[4]

The OIG noted deficiencies in six of the seven clinical areas reviewed and issued 11 recommendations that are attributable to the director, associate director, and chief of staff. These are briefly described below.

Medical Staff Privileging

The facility generally complied with requirements for privileging. However, the OIG identified concerns in the focused and ongoing professional practice evaluation processes.[5]

Environment of Care

The facility generally complied with requirements for cleanliness and safety. In addition, the OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with performing weekly inspections of the essential electrical system.

Medication Management

Overall, the facility complied with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, requirements for controlled

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[3] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

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

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

substances inspectors, and pharmacy inspections. However, the OIG identified noncompliance with reconciliation of dispensing between pharmacy and each dispensing area, which is a repeat finding from the 2013 and 2015 OIG Combined Assessment Program Reviews.[6] In addition, the OIG found a deficiency in verification of controlled substances orders.

Mental Health

The OIG team also found the facility complied with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator and tracking of MST-related data. The OIG noted a deficiency with providers not completing the MST mandatory training requirement.

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications and provided patient and/or caregiver education related to the newly prescribed medications. However, the OIG identified concerns with clinicians not adequately assessing patient/caregiver understanding when education was provided for new medications and with reconciling medication.

Women's Health

The OIG also noted the facility had processes in place for the provision of women's health: designation of a women veteran program manager, appointment of a women's health medical director, tracking of data related to cervical cancer screenings, communication of results to patients within the required time frame, and providing follow-up care when needed. However, the Women Veterans Health Committee charter for membership lacked representation from Quality Management and business office/non-VA medical care.

Summary

In reviewing key healthcare processes, the OIG issued 11 recommendations for improvement directed to the facility director, associate director, and chief of staff. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

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[6] VA Office of Inspector General, *Combined Assessment Program Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas*, Report No. 15-04696-107, February 9, 2016; VA Office of Inspector General, Combined Assessment Program Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas, Report No. 13-00893-195, May 9, 2013.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See appendixes E and F, pages 63–64, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

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

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[7] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[8] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

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

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

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

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

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

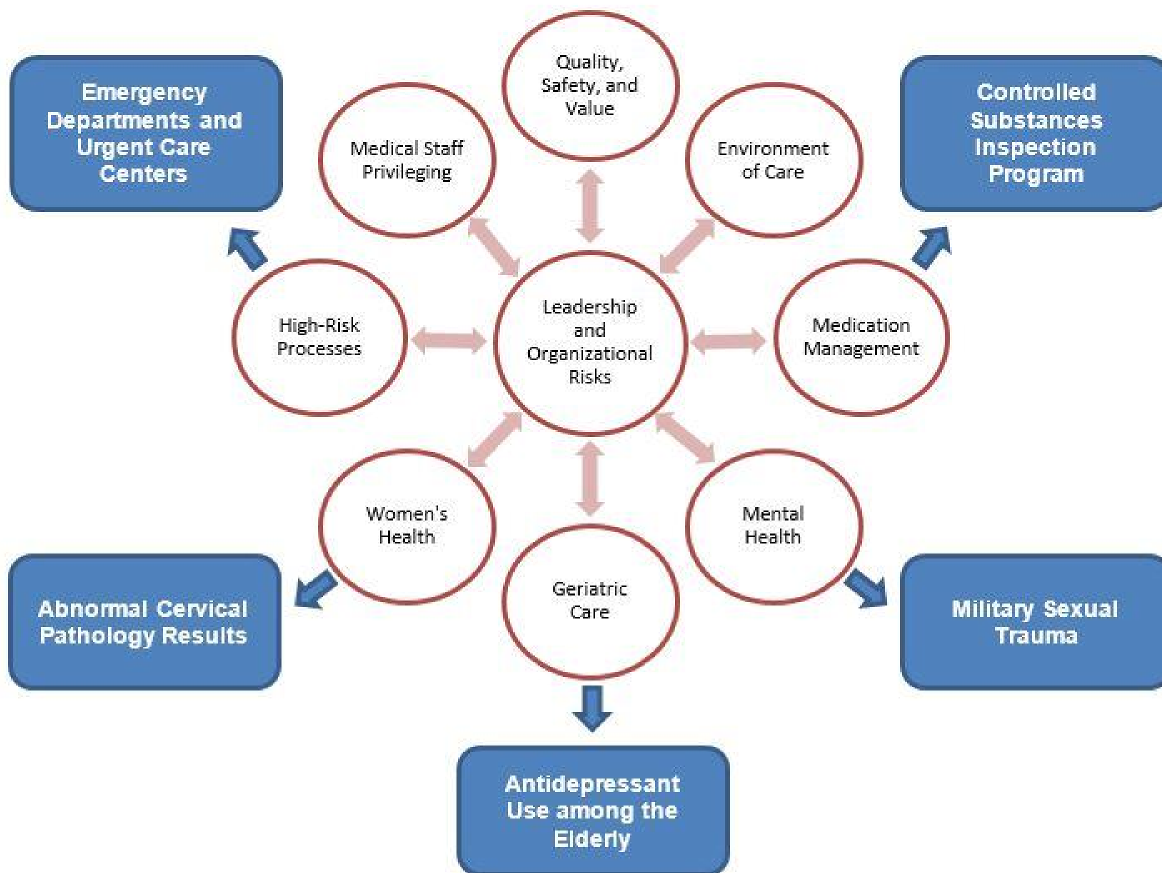

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

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

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[10] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from November 7, 2015, through May 9, 2019, the last day of the unannounced site visit.[11] Following the on-site visit, the OIG referred an issue and concern beyond the scope of the CHIP review to the Hotline management team for further evaluation.

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

The OIG conducted this inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[12] To assess the facility's risks, the OIG considered the following indicators:

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

Executive Leadership Position Stability and Engagement

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

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

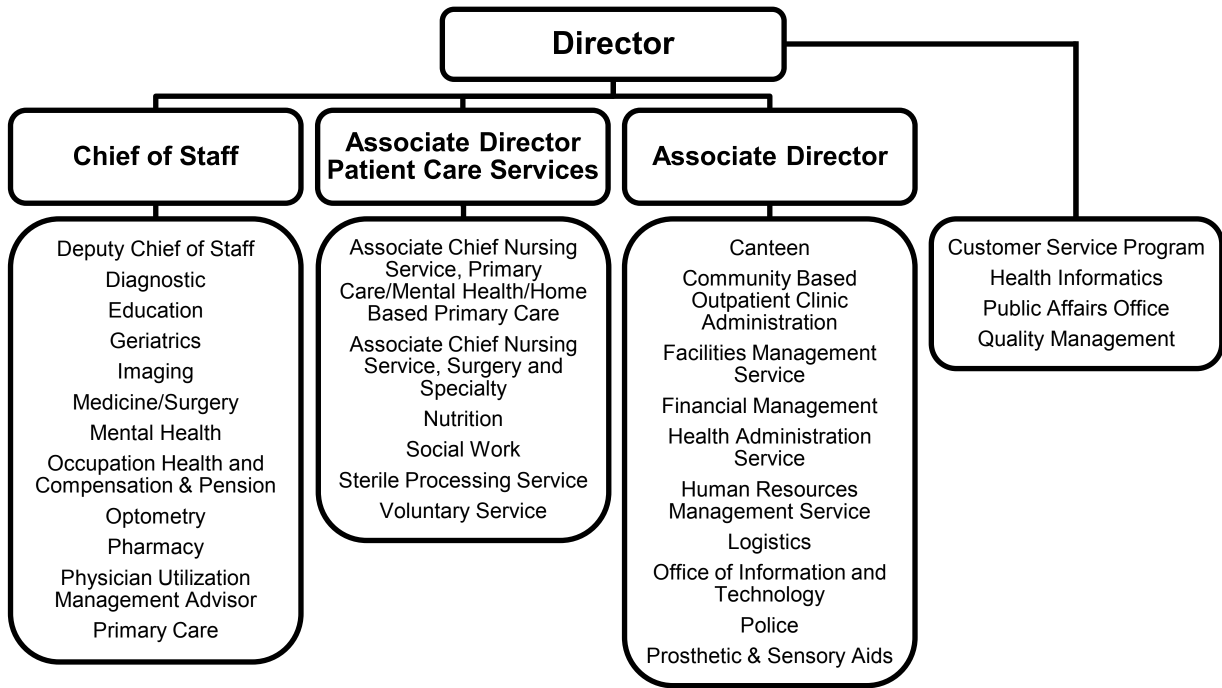

Figure 3. *Facility Organizational Chart*[13]
Source: VA Texas Valley Coastal Bend Health Care System (received May 8, 2019)

At the time of the OIG site visit, the executive team had been working together for approximately nine months. All team members were in previous roles at the facility prior to being permanently assigned to an executive position (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	January 20, 2019 (permanent); April 29, 2018, to January 19, 2019 (acting)
Chief of staff	May 12, 2019 (permanent); April 17, 2018, to May 2, 2019 (acting)
Associate director for Patient Care Services	July 8, 2018
Associate director	April 14, 2019 (permanent); August 5, 2018, to April 13, 2019 (acting)

Source: VA Texas Valley Coastal Bend Health Care System interim human resources officer provided the list on May 8, 2019, and an updated list was provided May 23, 2019.

To help assess facility executive leaders' engagement, the OIG interviewed the director, acting deputy chief of staff (who was covering for the chief of staff during the OIG on-site visit),

[13] At this facility, the director is responsible for the Customer Service Program, Health Informatics, Public Affairs Office, and Quality Management.

ADPCS, and associate director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leaders were generally able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve performance and employee and patient survey results. In addition, the executive leaders were generally informed within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed in greater detail below.

The director serves as the chairperson of the Joint Leadership Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Joint Leadership Council oversees various working groups, such as the Clinical Executive Board, Environment of Care Committee, Resource Management Committee, and the Integrated Ethics Committee.

These leaders are also engaged in monitoring patient safety and care through the Quality Executive Board, for which the director and chief of Quality Management are co-chairs. The Quality Executive Board is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and it reports to the Joint Leadership Council. See figure 4.

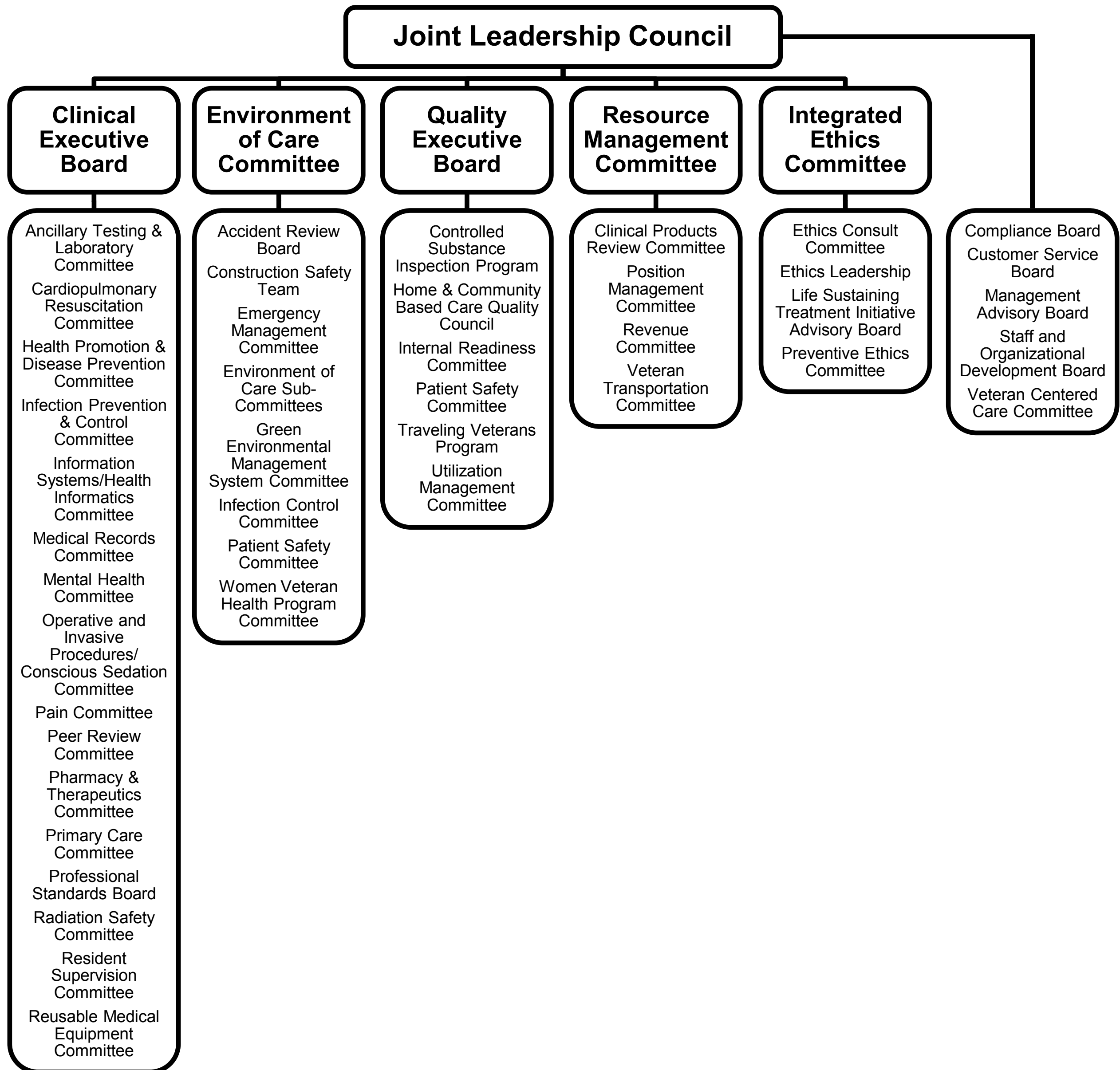

Figure 4. *Facility Committee Reporting Structure*[14]
Source: VA Texas Valley Coastal Bend Health Care System (May 7, 2019)

[14] The Joint Leadership Council oversees the Compliance Board, Customer Service Board, Management Advisory Board, Staff and Organizational Development Board, and Veteran Centered Care Committee.

Employee Satisfaction

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

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.[15] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for the selected survey leadership questions was similar to or higher than the VHA average.[16] The same trend was noted for the members of the executive leadership team. In all, employees appear generally satisfied with facility leaders.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[17]	0–100 where HIGHER scores are more favorable	71.7	73.2	86.7	82.5	92.5	74.5

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

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

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.2	3.9	3.6	3.9	3.2
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.4	3.8	3.9	3.9	3.4
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.1	3.8	3.7	3.6

Source: VA All Employee Survey (accessed April 4, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were similar to or better than the VHA average; however, for one survey question (in the past year, how often did you experience moral distress at work), the director's score was worse than VHA and the facility. Although facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns, the director has an opportunity to reinforce I CARE values,[18] specifically to promote a culture of safety and ensure employees are aware of the resources available to help when unsure of the correct course of action.

[18] "Integrity, Commitment, Advocacy, Respect, and Excellent (I CARE) define who the VA is, VA's culture, and help guide the actions of staff across VA. Staff – at every level within VA – play a critical role to support VA's commitment to care and serve our Veterans, their families, and beneficiaries." U.S. Department of Veterans Affairs, "I CARE," Core Values https://www.va.gov/icare/. (The website was accessed on May 29, 2019, and August 17, 2019.)

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.8	4.4	4.3	4.5	3.8
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.8	3.9	4.5	4.2	3.6
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.4	2.6	1.6	1.3	1.5

Source: VA All Employee Survey (accessed April 4, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leaders and compares the results to the overall VHA averages.[19]

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to relevant survey questions that reflect patients' attitudes toward facility leaders (see table 4). Of the two survey questions, the outpatient patient-centered medical home average was lower than VHA average, and the outpatient specialty care rating reflected higher care averages than VHA. Patients seem generally satisfied with the leadership and care provided. Facility leaders appeared to be actively engaged with patients, for example, through the interaction with patients during leadership rounding and implementation of a centralized call system, which included a telephone nurse triage process.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*[20]	The response average is the percent of "Definitely Yes" responses.	66.9	n/a
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	n/a

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

[20] The facility does not provide inpatient care; therefore, the facility average for two inpatient survey questions is not applicable (n/a).

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.3	73.9
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.5	77.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[21] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[22] Indicative of effective leadership, the facility has closed all recommendations for improvement.[23]

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

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

[23] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[24]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas, Report No. 15-04696-107, February 9, 2016*)	November 2015	14	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas, Report No. 15-05149-88, January 28, 2016*)	November 2015	2	0
TJC Ambulatory Health Care Accreditation	August 2017	8	0
TJC Behavioral Health Care Accreditation		0	n/a
TJC Home Care Accreditation		4	0

Sources: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on May 7, 2019)

[24] According to VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. https://www.cap.org/about-the-cap. (The website was accessed on February 20, 2019.); In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from November 7, 2015 (the prior comprehensive OIG inspection), through May 9, 2019.[25]

Table 6. Summary of Selected Organizational Risk Factors (November 7, 2015, through May 9, 2019)

Factor	Number of Occurrences
Sentinel Events[26]	0
Institutional Disclosures[27]	5
Large-Scale Disclosures[28]	0

Source: VA Texas Valley Coastal Bend Health Care System's ADPCS provided the sentinel events and large-scale disclosure information on May 6, 2019, and the chief of Quality Management provided the institutional disclosures on May 7, 2019)

Patient safety indicators, developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services, provide information on potential in-hospital

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[25] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the VA Texas Valley Coastal Bend Health Care System is a low complexity (3) affiliated facility as described in Appendix B.)

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

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

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

complications and adverse events following surgeries and procedures.[29] This data is not applicable since inpatient care is not provided at the facility.

Veterans Health Administration Performance Data

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

VA also uses a star-rating system where facilities with a “5-star” rating are performing within the top 10 percent of facilities and “1-star” facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[31] As of June 30, 2018, the facility was rated as “2-star” for overall quality.

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

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

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

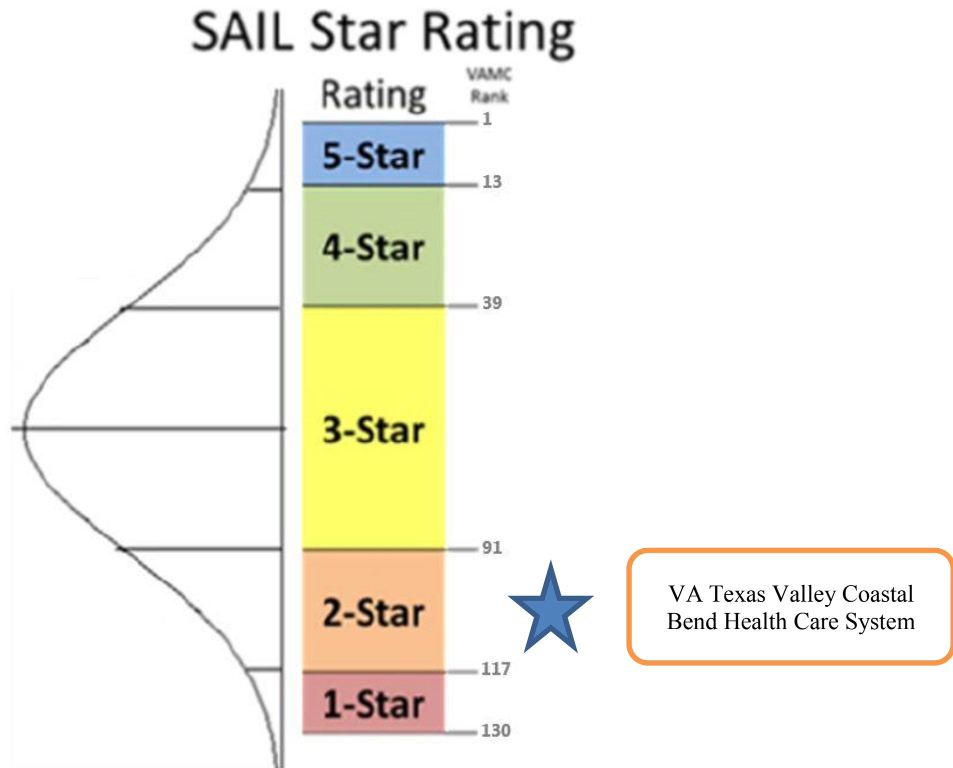

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed April 4, 2019)

Figure 6 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of patient-centered medical home (PCMH) same day appointment (Appt), mental health (MH) population (Popu) coverage, and mental health (MH) continuity (of) care). Metrics that need improvement are denoted in orange and red (for example, call responsiveness, ambulatory care sensitive conditions (ACSC) hospitalization, and patient-centered medical home (PCMH) care coordination).[32]

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

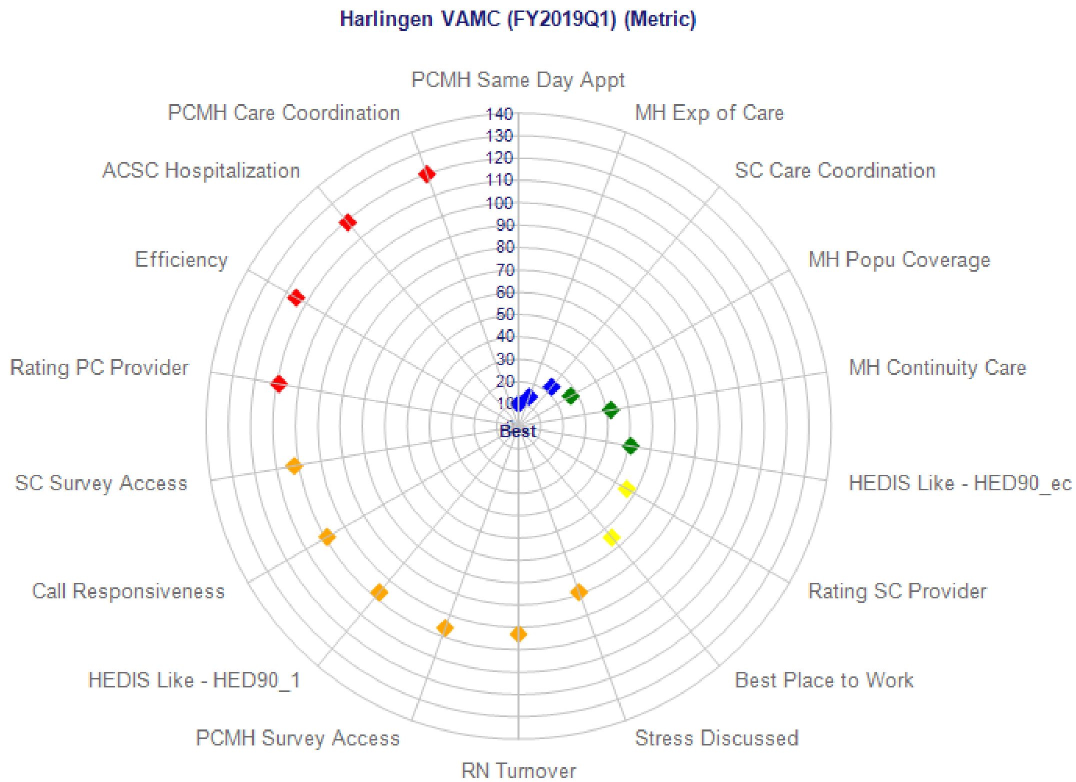

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in appendix D.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable even though three of the four positions were permanently filled less than six months prior to the OIG's on-site visit. Of note, each executive leader had served in an acting capacity in their current position prior to being selected for the position permanently. As for the chosen survey scores related to employees' satisfaction with the facility executive leaders, the facility averages were generally better than the VHA averages. The two applicable patient experience survey questions for this facility showed one survey score above and one survey score below VHA averages. The facility leaders appeared actively engaged with employees and patients and were working to sustain and further improve employee and patient engagement and satisfaction. The leaders also seemed to support efforts to improve and maintain patient safety, quality care, and other positive outcomes (such as initiating plans to maintain positive perceptions of the facility through active stakeholder engagement).

The OIG's review of the facility's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL metrics but should continue to take actions to sustain and improve performance of measures contributing to the SAIL "2-star" quality rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care while seeking continuous improvement.[33] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[34] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[35]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[36] utilization management (UM) reviews,[37] patient safety incident reporting with related root cause analyses,[38] and cardiopulmonary resuscitation (CPR) episode reviews.[39]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[40]

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

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

[35] VHA Directive 1026.

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

[37] According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired on July 31, 2019.

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

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

[40] VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[41]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[42]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[43]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[44]

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

[41] VHA Directive 1117(2).

[42] VHA Handbook 1050.01.

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

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

  - Peer review of all applicable deaths within 24 hours of admission to the hospital[45]
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[46]
- UM[47]
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[48]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

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[45] The facility does not provide inpatient care; therefore, review of deaths within 24 hours of admission was excluded from this review.

[46] The facility does not provide inpatient care; therefore, review of completed suicides within seven days after discharge from an inpatient mental health unit was excluded from this review.

[47] The facility does not provide inpatient care.

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

Quality, Safety, Value Conclusion

The OIG found general compliance with requirements for protected peer reviews and patient safety. However, the OIG identified a concern where a facility committee did not review the single resuscitation episode that occurred over the past 12 months. The lack of committee review reduces the ability to identify issues critical to improving patient outcomes. The committee chair stated the facility interpreted the VHA directive[49] as requiring the review of data and trends necessary for performance improvement during resuscitative events instead of reviewing the individual resuscitative episodes themselves. The OIG made no recommendations.

[49] VHA Directive 1177.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all healthcare professionals who are permitted by law and the facility to practice independently"—"without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[50]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to their expiration.[51]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluations (OPPE), are essential to confirm the quality of care delivered."[52]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular time frame and customized to the specific provider and related clinical concerns.[53] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[54]

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

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

[51] VHA Handbook 1100.19.

[52] VHA Handbook 1100.19.

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

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

- Three solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[55]
- Six LIPs hired within 18 months before the site visit
- Twenty LIPs reprivileged within 12 months before the visit
- No providers underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[56]
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and time frames clearly documented
  - Evaluation by another provider with similar training and privileges
  - Executive Committee of the Medical Staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

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[55] The 18-month period was from November 6, 2017, through May 6, 2019. The 12-month review period covered May 6, 2018, through May 6, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

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

- Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
- Evaluation by another provider with similar training and privileges
- Executive Committee of the Medical Staff's decision to recommend continuing privileges based on OPPE results

- Focused professional practice evaluations for cause
    - Clearly defined expectations/outcomes
    - Time-limited
    - Provider's ability to practice independently not limited for more than 30 days
    - Shared with the provider in advance
- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG identified concerns with FPPE and OPPE processes which warranted recommendations for improvement.

Specifically, VHA requires the criteria for the FPPE process "to be defined in advance, using objective criteria accepted by the practitioner."[57] The OIG reviewed six practitioners' profiles and found that all of them lacked evidence that providers were aware of the criteria for evaluation before initiation of the FPPE process. This could result in providers' misunderstanding of the FPPE expectations. The acting deputy chief of staff reported that FPPE information was communicated verbally to providers upon initial orientation, however, the communication was not documented.

Recommendation 1

1. The chief of staff ensures that clinical managers define the focused professional practice evaluation process in advance and monitors clinical managers' compliance.

[57] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. On September 16, 2019, the Focused Professional Practice Evaluation forms were updated to include an attestation statement and signature line to confirm that the focused professional practice evaluation criteria was reviewed with the provider during physician orientation. 100% of completed Focused Professional Practice Evaluation forms beginning on December 1, 2019 to May 31, 2020 will be reviewed monthly to verify that the Focused Professional Practice Evaluation form was signed by the provider and continue until a compliance rate of 90% is achieved.

Numerator = Number of forms signed by the new provider

Denominator = All Focused Professional Practice Evaluation forms submitted to Professional Standards Board per month

The Chief of Staff will conduct the review and the report will be presented at the Professional Standards Board monthly meeting on an ongoing basis to monitor for compliance and sustainment.

VHA requires that at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of LIPs' privileges to the executive committee of the medical staff.[58] Such data are maintained as part of the practitioner's profile and may include direct observations, clinical discussions, and clinical record reviews. The OPPE process "is essential to confirm the quality of care delivered. This allows the facility to identify professional practice trends that impact the quality of care and patient safety."[59]

For 18 of 23 LIPs who were reprivileged, service chiefs' determinations to continue privileges were not based on results of OPPE activities. For eight of these providers' OPPEs, evidence was not provided when requested by the OIG and, therefore, inclusion of service-specific OPPE criteria could not be validated. Also, the facility's Clinical Executive Board recommended continuation of privileges with incomplete OPPE results or without submission of OPPE evidence to the Board for review and discussion. As a result, these providers continued to deliver care without a thorough evaluation of their professional practice trends. The acting deputy chief of staff reported that the services do not have a standardized process in place to track OPPE evidence and that off-site virtual clinicians pose challenges in developing a process.

[58] VHA Handbook 1100.19.

[59] VHA Handbook 1100.19.

Recommendation 2

2. The chief of staff confirms that clinical managers ensure ongoing professional practice evaluations include service-specific criteria and monitors clinical managers' compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. On May 22, 2019, the Ongoing Professional Performance Evaluation forms were updated to include specialty-specific criteria. 100% of all Ongoing Professional Performance Evaluation forms submitted to the Professional Standards Board for approval between October 2019 and March 2020 will be reviewed monthly to verify inclusion of specialty-specific criteria.

Numerator = Number of Ongoing Professional Performance Evaluations with specialty specific criteria provided to Professional Standards Board

Denominator = all Ongoing Performance Professional Performance Evaluations forms from October 2019 and March 2020 submitted monthly to Professional Standards Board

A compliance rate of 90% will be achieved for six consecutive months. The data will be presented at the Professional Standards Board monthly meeting on an ongoing basis to monitor for compliance and sustainment.

Recommendation 3

3. The chief of staff makes certain that service chiefs collect and review ongoing professional practice evaluation data and that the facility's Clinical Executive Board reviews the data in the consideration to recommend continuation of provider privileges, and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. On October 1, 2019, a secure, shared folder was created to maintain all provider Ongoing Professional Practice Evaluations (OPPE). 100% of OPPEs will be submitted by Service Chiefs and reviewed and reconciled monthly. A compliance rate of 90% will be achieved for six consecutive months.

Numerator = the number of OPPE provider data that was reviewed by both service chief and Clinical Executive Board

Denominator = Number of provider's recredentialed each month

All OPPEs reported to the Professional Standards Board will be reconciled against the shared folder (housed in Chief of Staff secure folder) in order to ensure that reported OPPE data is complete prior to Professional Standards Board meeting. The data will be presented at the Professional Standards Board chaired by Chief of Staff bi-monthly meeting on an ongoing basis to monitor for compliance and sustainment. Executive summary of Professional Standards Board is presented at Clinical Executive Board on a monthly basis.

In addition, VHA has defined specialty-specific elements to be used, where appropriate, for gastroenterology, pathology and laboratory medicine, nuclear medicine, and radiation oncology specialties.[60] The OPPE process ensures a consistent approach for evaluating providers in these specialties and is essential to confirming the quality of care delivered.[61]

The OIG noted that the OPPE data for the one gastroenterology solo/few provider did not include the elements required by VHA. This resulted in insufficient evidence to confirm the quality of care delivered by the provider. The acting deputy chief of staff was unaware that specialty criteria was required in the clinicians' OPPE profile until February 1, 2019, when the facility received notice from the VISN.

Recommendation 4

4. The chief of staff makes certain that clinical managers include required specialty-specific criteria in ongoing professional practice evaluations for solo/few gastroenterology practitioners and monitors clinical managers' compliance.

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

[61] VHA Handbook 1100.19.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Staff is responsible for compliance of this recommendation. Ongoing Professional Practice criteria for Gastroenterology has been revised to include the required standard elements and was approved by the Professional Standards Board on May 22, 2019. An audit will be conducted by staff assigned to the Chief of Staff office for 6 months to ensure that the form containing specialty-criteria is being used. Target rate is 100%.

Numerator = # of Gastroenterology OPPE forms with required standard elements

Denominator = # of Gastroenterology providers evaluated over 6 months.

A compliance rate of 90% will be monitored for six consecutive months. The data will be presented at the Professional Standards Board Chaired by Chief of Staff monthly meeting on an ongoing basis to monitor for compliance and sustainment. Executive summary of Professional Standards Board is presented at Clinical Executive Board on a monthly basis.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional, but should also promote healing.[62]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[63]

VHA requires its facilities to have the "capacity for providing mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[64]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[65] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,[66]

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

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

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

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

[66] VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA Directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,[67] and National Fire Protection Association standards.[68] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[69]

At the parent facility, the OIG team inspected 17 areas—prosthetics; main hall administrative offices; mental health outpatient; urology; ear, nose, and throat; dermatology; oncology; podiatry; rheumatology; neurology; pulmonary; general surgery; respiratory; eye clinic; gastrointestinal procedures; pre-operation; and pre-operation holding.-The team also inspected the South Enterprize VA Clinic. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit[70]
  - Mental health environment of care rounds

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

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

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

[70] The facility does not have an inpatient mental health unit.

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

Environment of Care Conclusion

Generally, the facility met cleanliness and safety requirements associated with the above performance indicators. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified a deficiency in performing weekly inspections of the essential electrical system that warranted a recommendation for improvement.

Specifically, VHA requires that the "[essential electrical system], including all related components, such as [a]utomatic [t]ransfer [s]witches and emergency generators, must be inspected weekly."[71] The OIG requested verification that weekly essential electrical system inspections occurred, however, the facility was not able to provide evidence. When the emergency electrical power supply system is not inspected, the system may fail during a power disruption, leaving providers unable to deliver safe care, treatment, and services to patients.[72] The facility engineer was unaware that the essential electrical power system required weekly inspections and had believed the facility was considered a business occupancy building and not a hospital.

Recommendation 5

5. The associate director ensures that facility engineers conduct weekly electrical system inspections and monitors compliance.

[71] VHA Directive 1028.

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

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Associate Director is responsible for compliance of this recommendation. By October 31, 2019, the generator testing inspection form will be updated to include weekly inspection of the transfer switches. Facility personnel are enrolled in the Certified Healthcare Emergency Power Professionals Program through the Motor and Generator Institute to be completed by February 2020. Facility Management staff that will be trained include Chief Engineer, Administrative Office for Associate Director, Operations Administrator, Environment management officer, Maintenance worker and Safety Officer. Safety personnel report to the Facilities management Services. Facility and Safety personnel are working together to ensure all generators at each location are tested according to manufacture standards. Standard Operating Procedures have been established stating, at a minimum the items that need to be checked on a weekly and monthly basis in accordance with VHA Directive 1028 and NFPA 110. Monitoring for 100% compliance will be conducted by the Safety Officer, Chief of Facilities Management Service and the Operations Administrator for six months until 100% compliance is met.

Monitoring of weekly generator inspections will continue until 100% compliance rate is achieved for six consecutive months for all generators.

Numerator = Number of weekly generators inspections completed

Denominator = Total Number of generators

The report will be presented at Environment of Care Committee on a monthly basis.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[73] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[74]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[75]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;[76] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
    - Monthly summary of findings to the director
    - Quarterly trend reports to the director
    - Quality Management Committee's review of monthly and quarterly trend reports
    - Actions taken to resolve identified problems
- Pharmacy operations
    - Staff restrictions for monthly review of balance adjustments[77]
- Requirements for controlled substances inspectors

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

[74] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

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

[76] The two quarters were from October 1, 2018, through March 31, 2019.

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

- No conflicts of interest
- Appointed in writing by the director for a term not to exceed three years
- Hiatus of one year between any reappointment
- Completion of required annual competency assessment

- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction[78]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of twice a week (3 days apart) inventories of the main vault[79]
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[80]

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

[79] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

[80] When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists' review of medications ordered by the providers, however the automated dispensing cabinets at the facility did not have overrides.

Medication Management Conclusion

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, requirements for controlled substances inspectors, and pharmacy inspections. However, the OIG noted that the staff responsible for conducting the monthly review of balance adjustments also had the security key to perform and document the balance adjustments; this was corrected while the OIG was still on site. The OIG also identified the following areas of concern, outside the scope of the CHIP review, in pharmacy operations—lack of investigation regarding a dispensing error with morphine sulfate tablets, delay in completing a balance adjustment, and holding drugs for destruction for over two years which were referred for OIG hotline evaluation. The OIG identified noncompliance with reconciliation of dispensing between pharmacy and each dispensing area and verification of controlled substances orders which warranted recommendations for improvement.

Specifically, VHA requires controlled substances inspection program staff to reconcile one random day's refilling from the pharmacy to every automated dispensing unit and one random day's return of stock to pharmacy from every automated dispensing unit during controlled substances area inspections.[81] The OIG found that for October 2018 to March 2019, all three non-pharmacy areas lacked reconciliation of one-day dispensing from the pharmacy and one-day return to stock. This is a repeat finding from the 2013 and 2015 OIG Combined Assessment Program Reviews.[82] Failure to reconcile dispensing and returns in all controlled substances areas may cause delays in identifying potential drug diversion activities.

The controlled substances coordinator stated that the controlled substances inspection staff did not perform this reconciliation process consistently due to their rotation schedule. The controlled substances coordinator also reported that supporting documentation was not kept for this review because these reports can be reproduced.

Recommendation 6

6. The facility director makes certain that controlled substances inspection staff reconcile one day's stocking/refilling from the pharmacy to each dispensing area and one day's return of stock to pharmacy and that the controlled substances coordinator evaluates and maintains supporting documentation, and the facility director monitors coordinator's compliance.

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[81] VHA Directive 1108.02(1).

[82] VA Office of Inspector General, *Combined Assessment Program Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas*, Report No. 15-04696-107, February 9, 2016; VA Office of Inspector General, *Combined Assessment Program Review of the VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas*, Report No. 13-00893-195, May 9, 2013.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Quality Management is responsible for this recommendation. By October 31, 2019 the Controlled Substance Inspection form will be revised to include verification of reconciliation of one day's stocking/refilling from the pharmacy to each dispensing area and one day's return of stock to pharmacy. Controlled Substance Coordinator will review 100% of the Controlled Substance Inspection reports on a monthly basis.

Numerator = Number of times Controlled Substance Inspectors verify documentation verification of reconciliation occurred between cabinet and pharmacy and pharmacy to cabinet each month

Denominator = Number of non-pharmacy inspections each month

A compliance rate of 90% will be maintained for six consecutive months and reported monthly to Quality Executive Board.

VHA requires that controlled substances inspectors verify during controlled substances inspections that there is evidence of documentation of two signatures for any waste of partial doses for five randomly selected dispensing activities.[83] For all three non-pharmacy areas reviewed, the controlled substances inspectors did not verify documentation of two signatures for waste when partial doses were administered. This may result in the inability to account for all controlled substances. The controlled substances coordinator reported that the controlled substances inspectors are trained to focus on whether there are partial doses requiring waste, but the worksheet has not been modified to include an area to document findings.

Recommendation 7

7. The facility director ensures that the controlled substances inspectors verify documentation for two signatures for any waste of partial doses and monitors controlled substances inspectors' compliance.

[83] VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Quality Management is responsible for this recommendation. On September 25, 2019 the Controlled Substance Inspection form was revised to include verification of documentation of two signatures for any wastage of partial doses administered. On a monthly basis for six months the Control Substance Coordinator will review 100% of inspection forms of all partial doses administered to verify compliance.

Numerator = Number of times partial dose and two signatures are completed.

Denominator = Number of times partial dose is given.

A compliance rate of 90% will be maintained for six consecutive months and reported monthly to Quality Executive Board.

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

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department of Veterans Affairs, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[84] "MST is an experience, not a diagnosis or a mental health condition." Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[85]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[86] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[87]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system (CPRS).[88] Those who screen positive must have access to appropriate MST-related care.[89] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[90]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[91] All mental health and primary care providers must complete MST mandatory

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

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

[86] VHA Directive 1115.

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

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

[89] VHA Directive 1115.

[90] VHA Handbook 1160.01.

[91] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[92]

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

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

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator and tracking of MST-related data. However, the OIG determined that mental health and primary care providers were not meeting the MST mandatory training requirement, which warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[93] The OIG found 7 of 18 providers hired after July 1,

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

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

2012, did not complete the required MST mandatory training within 90 days after entering their position. This could potentially prevent clinicians from providing appropriate counseling, care, and service to patients who have experienced MST. The acting associate chief of staff for Mental Health Services believed primary care and mental health providers were inconsistently assigned the required training and admitted to a lack of oversight in the training process.

Recommendation 8

8. The chief of staff ensures that providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff is responsible for this recommendation. On September 1, 2019, the Military Sexual Trauma Coordinator created a system to ensure accurate assignment and completion of the MST mandatory training in Talent Management System (TMS) to ensure full compliance. Military Sexual Trauma Coordinator continues to work with the VISN TMS Domain Manager, VHA Instructional Systems Specialist, local Nurse Educator (Education Department), Chief of Psychology and local TMS support to identify and solve issues related to the accurate assignment of trainings in TMS. MST coordinator is now being alerted to the list of new employees who start each pay period. MST coordinator has enhanced the tracking system to include alerts in order to ensure that new employees were both automatically and manually reminded to complete the MST mandatory training. This alert system will be operated and monitored by the MST coordinator. Employees will be alerted after 30, 60, 75, 85 and 89 days of non-completion. The MST coordinator will utilize the assistance of the employee's supervisor, department chiefs and chief quality management to assist with completion of training. Effective October 1, 2019 the Military Sexual Trauma Coordinator will monitor to ensure that 100% of staff complete the training within 90 days of hire to the position.

Numerator = Number of new staff who completed the MST TMS training within 90 days of hire to the position

Denominator = Number of new staff who are required to take the Military Sexual Trauma training

Compliance will be reported to the Clinical Executive Board on a monthly basis until 100% compliance has been sustained for no less than 6 consecutive months.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 percent of veterans aged 65 years and older have a diagnosis of major depressive disorder."[94] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[95]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 percent of older adults have at least one chronic health condition and 50 percent have two or more." Further, "most older adults see an improvement in their symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[96]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[97] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[98] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[99] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[100] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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

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

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

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

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

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

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

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[101]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 37 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[102] The OIG evaluated the following performance indicators:

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

Geriatric Care Conclusion

For geriatric patients, clinicians documented reasons for prescribing medications and provided education about the newly prescribed medications. However, the OIG identified concerns with inadequate assessments of patient/caregiver's understanding when education was provided for new medications and with reconciling medications that warranted recommendations for improvement.

TJC requires that clinicians evaluate the patient's understanding of the education and training provided regarding newly prescribed medications.[103] The OIG estimated that clinicians assessed patient/caregiver understanding of education about newly prescribed medications for 76 percent of the patients at the facility, based on electronic health records reviewed.[104] Providing medication education and assessing understanding is critical to ensuring that patients or their caregivers have the information they need to "manage their own health at home."[105] In addition, the pharmacy supervisor stated they are busy at the pickup window and do not have time to document that education was provided and understanding was assessed.

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

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

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

[104] The OIG is 95 percent confident that the true compliance rate is somewhere between 61.7 and 89.0 percent, which is statistically significantly below the 90 percent benchmark.

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

Recommendation 9

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

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff is responsible for this recommendation. On August 22, 2019, training education was provided for Mental Health and Primary Care providers regarding expectations when prescribing antidepressants in the 65 years or greater population. The medication reconciliation template was revised on September 27, 2019 to include clinician documentation on assessment of the patient's understanding of specific education about the safe and effective use of the newly prescribed antidepressants.

Numerator = number of patients (to exclude non-VA care) with appropriate documentation of the assessment of the patient and caregiver's understanding of education about the safe and effective use of newly prescribed antidepressant medications

Denominator = the number of patients (to exclude non-VA care) 65 or older who are newly prescribed antidepressants

A report containing 100% of all newly prescribed antidepressants for patients greater than 65 years of age with sample size of 5 chart reviews per month will be performed by Clinical Pharmacy Specialists until a compliance rate of 90% is maintained for six consecutive months. The results will be reported to the Clinical Executive Board monthly.

According to TJC, In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.[106] The OIG estimated that medication reconciliation was performed for 54 percent of the patients at the facility, based on electronic health records reviewed.[107] Failure to reconcile medications increases the risk that there may be "duplications, omissions, and interactions" in the patient's actual drug regimen.[108] Clinical managers stated that the facility's documentation template and process prevents the completion of medication reconciliation. For example, when a provider enters a new medication order, it is in a pending status which triggers the need for medication reconciliation. When the pharmacy acts on the order, the pending status changes and the medication is considered a current medication. If this

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

[107] The OIG is 95 percent confident that the true compliance rate is somewhere between 37.8 and 70.3 percent, which is statistically significantly below the 90 percent benchmark.

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

happens before the provider compares the patient's current medications with the newly ordered drugs, the provider will not get the trigger to perform medication reconciliation.

Recommendation 10

10. The chief of staff ensures clinicians reconcile medications and maintain accurate medication information in patients' electronic health records and monitors clinicians' compliance.

Facility concurred.

Target date for completion: March 31, 2020

Facility response: The Chief of Staff will be responsible for this recommendation. Education was provided to the Providers on 9/30/2019 about expectations when prescribing medications in this population, including the medication reconciliation requirement. A report was created to ensure that all patients over 65 years of age who are prescribed these medications by providers are meeting all the guidelines, including the medication reconciliation component. The Medication Reconciliation template was modified on 9/26/2019.

Numerator = number of accurate medical reconciliations with appropriate documentation of assessment of education provided for all patients, 65 or greater, with newly prescribed antidepressants

Denominator = number of medication reconciliations for all patients, 65 or greater, with newly prescribed antidepressants.

An audit of 5 charts per month will be reviewed by Clinical Pharmacy Specialists to ensure clinicians have provided accurate medication reconciliation until 100% compliance is achieved for six consecutive months. The results will be reported to the Clinical Executive Board monthly for no less than 6 consecutive months.

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

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

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

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

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

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

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

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

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

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

[114] VHA Directive 1330.01(2).

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

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

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

Women's Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and women's health medical director, tracking of data related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. However, the OIG noted noncompliance with the Women Veterans Health Committee membership that warranted a recommendation for improvement.

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

[115] VHA Directive 1330.01(2).

"representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership."[116] From October 2018 through April 2019, the committee charter did not include quality management or business office/non-VA medical care as core members. Despite this, the OIG team noted there was consistent committee attendance by the chief of Quality Management, but there was no participation by business office/Non-VA Medical Care representatives. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. Despite demonstrating a thorough knowledge of the VHA directive, the women veterans program manager cited the reason for noncompliance was an unawareness of the requirement for business office/non-VA medical care representation in the committee.

Recommendation 11

11. The chief of staff confirms that the Women Veterans Health Committee includes required core members and monitors committee's compliance.

Facility concurred.

Target date for completion: March 30, 2020

Facility response: The Chief of Staff is responsible for this recommendation The Women's Health Committee Charter was revised at the January 2019 Women's Health Committee meeting and approved by the Chief of Staff on May 13, 2019. The Charter now includes the participation of representatives from Quality Management and business office/non-VA Community Care. Leadership from each of these representative areas will be participating in the Women's Health Committee quarterly meetings. The Women's Health Care Coordinator will monitor attendance for required core member attendance until 90% compliance is achieved for two consecutive quarters. Women Veterans Health Committee chartered members in meeting attendance)/ denominator (number of Women Veterans Health Committee chartered members). The Women Veterans Health Committee meeting minutes will be presented and monitored by the Clinical Executive Board monthly.

[116] VHA Directive 1330.01(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• Clinical managers define the FPPE process in advance. • Clinical managers ensure OPPEs include service-specific criteria. • Service chiefs collect and review OPPE data and the facility’s Clinical Executive Board reviews the data in the consideration to recommend continuation of provider privileges. • Clinical managers include specialty-specific criteria in OPPEs for solo/few gastroenterology practitioners.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Community based outpatient clinic ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Emergency management ○ Hazard vulnerability analysis (HVA) ○ Emergency operations plan (EOP) ○ Emergency power testing and availability	• Weekly inspections of the essential electrical system are conducted and documented.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• Controlled substances staff reconcile one day's stocking/ refilling from the pharmacy to each dispensing area and one day's return of stock to pharmacy and the controlled substances coordinator evaluates and maintains supporting documentation. • Controlled substances inspectors verify documentation for two signatures for any waste of partial doses.	• None
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• Providers complete military sexual trauma mandatory training within the required time frame.	• None
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• Clinicians assess and document the patient/caregiver's understanding of education provided for newly prescribed medications. • Clinicians reconcile medication information and maintain accurate medication information in patients' electronic health records.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a WVPM • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• None	• The Women Veterans Health Committee includes required core members.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) affiliated[117] facility reporting to VISN 17.[118]

Table B.1. Facility Profile for A Texas Valley Coastal Bend Health Care System (740) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[119]	Facility Data FY 2017[120]	Facility Data FY 2018[121]
Total Medical Care Budget dollars	$247,932,205	$231,712,822	$314,624,669
Number of: • Unique Patients	33,845	34,638	36,469
• Outpatient Visits	384,654	396,233	438,896
• Unique Employees[122]	698	739	651

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

[117] Associated with a medical residency program.

[118] The VHA medical centers are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs."

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

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

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

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

VA Outpatient Clinic Profiles[123]

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

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)[124]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[125] Provided	Diagnostic Services[126] Provided	Ancillary Services[127] Provided
Harlingen, TX	740GA	35,011	10,695	Dermatology Endocrinology	Radiology	Nutrition Pharmacy Social work Weight management Dental

[123] Includes all outpatient clinics in the community that were in operation as of August 15, 2018. The OIG omitted North Tenth Street, McAllen, TX (740GJ), as no data was reported.

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

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

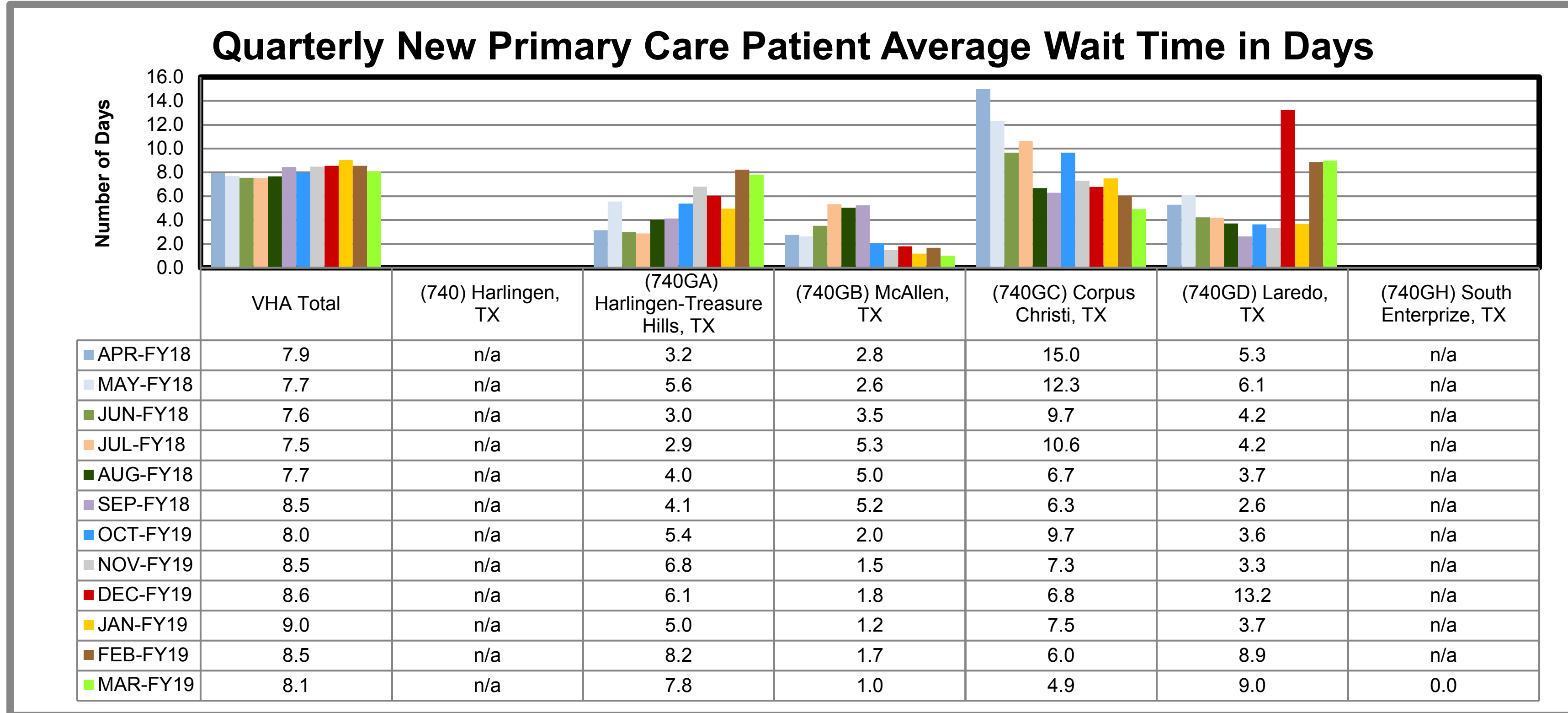
[126] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

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

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[125] Provided	Diagnostic Services[126] Provided	Ancillary Services[127] Provided
McAllen, TX	740GB	36,260	19,151	Dermatology Endocrinology Infectious disease Eye	Laboratory & Pathology Radiology	Nutrition Pharmacy Social work Weight management
Corpus Christi, TX	740GC	29,150	4,178	Dermatology Infectious disease	Laboratory & Pathology Radiology	Nutrition Pharmacy Social work Weight management
Laredo, TX	740GD	12,541	5,694	Dermatology Infectious disease Pulmonary/ Respiratory disease Podiatry	Laboratory & Pathology Radiology	Nutrition Pharmacy Social work Weight management
Corpus Christi, TX	740GH	1,993	11,840	Cardiology Infectious disease Neurology Pulmonary/ Respiratory disease Poly-Trauma Eye Orthopedics Podiatry	EMG Laboratory & Pathology	Pharmacy Dental
Corpus Christi, TX	740GI	n/a	4,511	n/a	n/a	n/a

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = not applicable

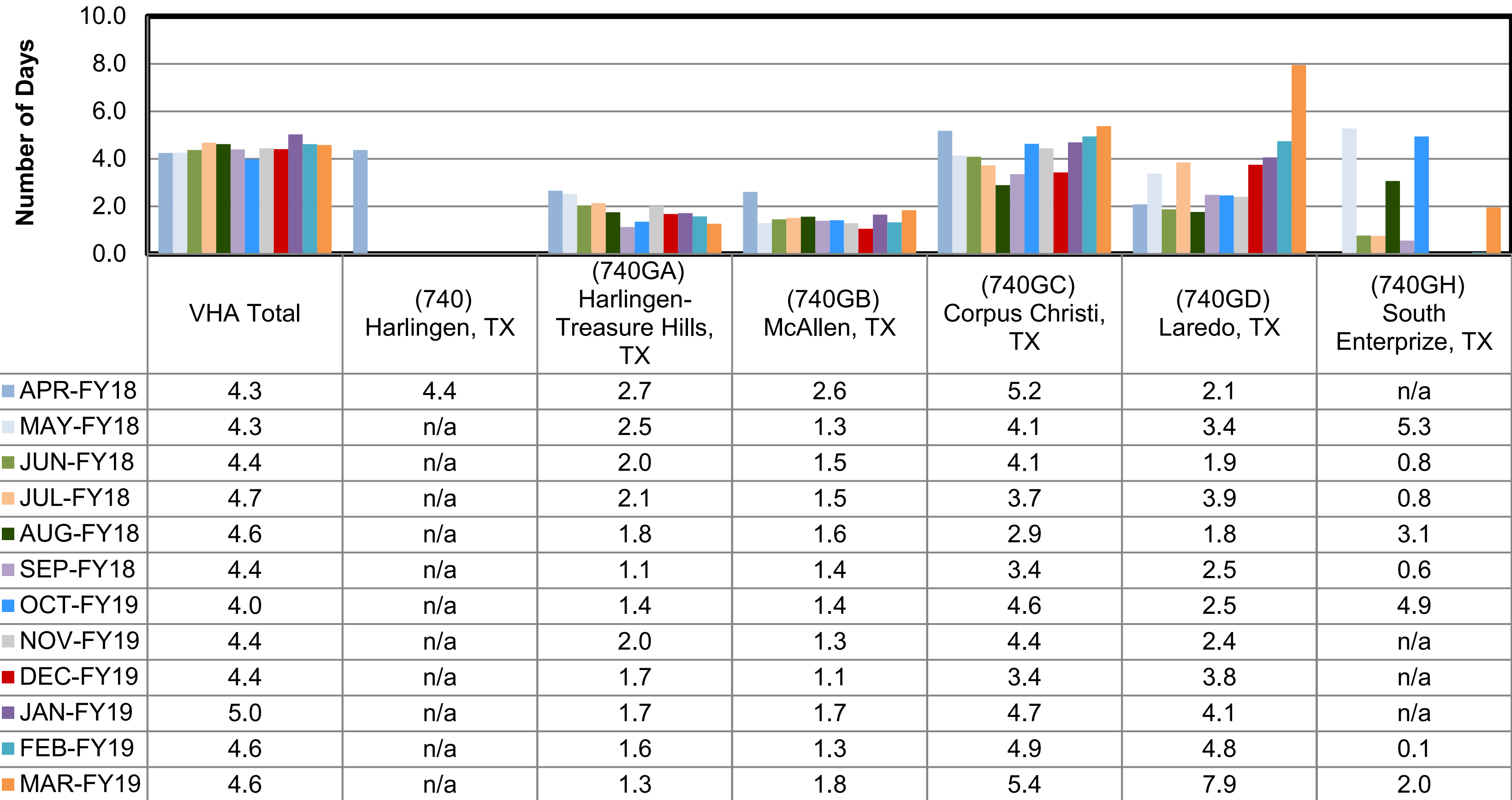
Appendix C: Patient Aligned Care Team Compass Metrics[128]



	VHA Total	(740) Harlingen, TX	(740GA) Harlingen-Treasure Hills, TX	(740GB) McAllen, TX	(740GC) Corpus Christi, TX	(740GD) Laredo, TX	(740GH) South Enterprize, TX
APR-FY18	7.9	n/a	3.2	2.8	15.0	5.3	n/a
MAY-FY18	7.7	n/a	5.6	2.6	12.3	6.1	n/a
JUN-FY18	7.6	n/a	3.0	3.5	9.7	4.2	n/a
JUL-FY18	7.5	n/a	2.9	5.3	10.6	4.2	n/a
AUG-FY18	7.7	n/a	4.0	5.0	6.7	3.7	n/a
SEP-FY18	8.5	n/a	4.1	5.2	6.3	2.6	n/a
OCT-FY19	8.0	n/a	5.4	2.0	9.7	3.6	n/a
NOV-FY19	8.5	n/a	6.8	1.5	7.3	3.3	n/a
DEC-FY19	8.6	n/a	6.1	1.8	6.8	13.2	n/a
JAN-FY19	9.0	n/a	5.0	1.2	7.5	3.7	n/a
FEB-FY19	8.5	n/a	8.2	1.7	6.0	8.9	n/a
MAR-FY19	8.1	n/a	7.8	1.0	4.9	9.0	0.0

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness The OIG omitted Old Brownsville, TX (740GI); and North Tenth Street-McAllen, TX (740GJ), as no data were reported.
Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY15, this metric was calculated using the earliest possible create date." The absence of reported data is indicated by "n/a."

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



	VHA Total	(740) Harlingen, TX	(740GA) Harlingen-Treasure Hills, TX	(740GB) McAllen, TX	(740GC) Corpus Christi, TX	(740GD) Laredo, TX	(740GH) South Enterprize, TX
APR-FY18	4.3	4.4	2.7	2.6	5.2	2.1	n/a
MAY-FY18	4.3	n/a	2.5	1.3	4.1	3.4	5.3
JUN-FY18	4.4	n/a	2.0	1.5	4.1	1.9	0.8
JUL-FY18	4.7	n/a	2.1	1.5	3.7	3.9	0.8
AUG-FY18	4.6	n/a	1.8	1.6	2.9	1.8	3.1
SEP-FY18	4.4	n/a	1.1	1.4	3.4	2.5	0.6
OCT-FY19	4.0	n/a	1.4	1.4	4.6	2.5	4.9
NOV-FY19	4.4	n/a	2.0	1.3	4.4	2.4	n/a
DEC-FY19	4.4	n/a	1.7	1.1	3.4	3.8	n/a
JAN-FY19	5.0	n/a	1.7	1.7	4.7	4.1	n/a
FEB-FY19	4.6	n/a	1.6	1.3	4.9	4.8	0.1
MAR-FY19	4.6	n/a	1.3	1.8	5.4	7.9	2.0

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Old Brownsville, TX (740GI); and North Tenth Street-McAllen, TX (740GJ), as no data were reported.
Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." The absence of reported data is indicated by "n/a."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[129]

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

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

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

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

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

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 18, 2019

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

Subj: Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System, Harlingen, TX

To: Director, Bay Pines Office of Healthcare Inspections (54CH03)

Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

Thank you for the opportunity to provide an initial response for the OIG CHIP Draft Report for the VA Texas Valley Coastal Bend Health Care System.

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

(Original signed by:)

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

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

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 30, 2019

From: Director, VA Texas Valley Coastal Bend Health Care System (740/00)

Subj: Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System, Harlingen, TX

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

1. Thank you for conducting the Comprehensive Healthcare Inspection (OIG) review during the week of May 6, 2019 at VA Texas Valley Coastal Bend Health Care System.

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

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

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

(Original signed by:)

Charles Harpel Associate Director for Homero S. Martinez III, MBA, Director

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

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