DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network

Arlington, Texas

CHIP REPORT | REPORT #19-06863-69 | JANUARY 15, 2020

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

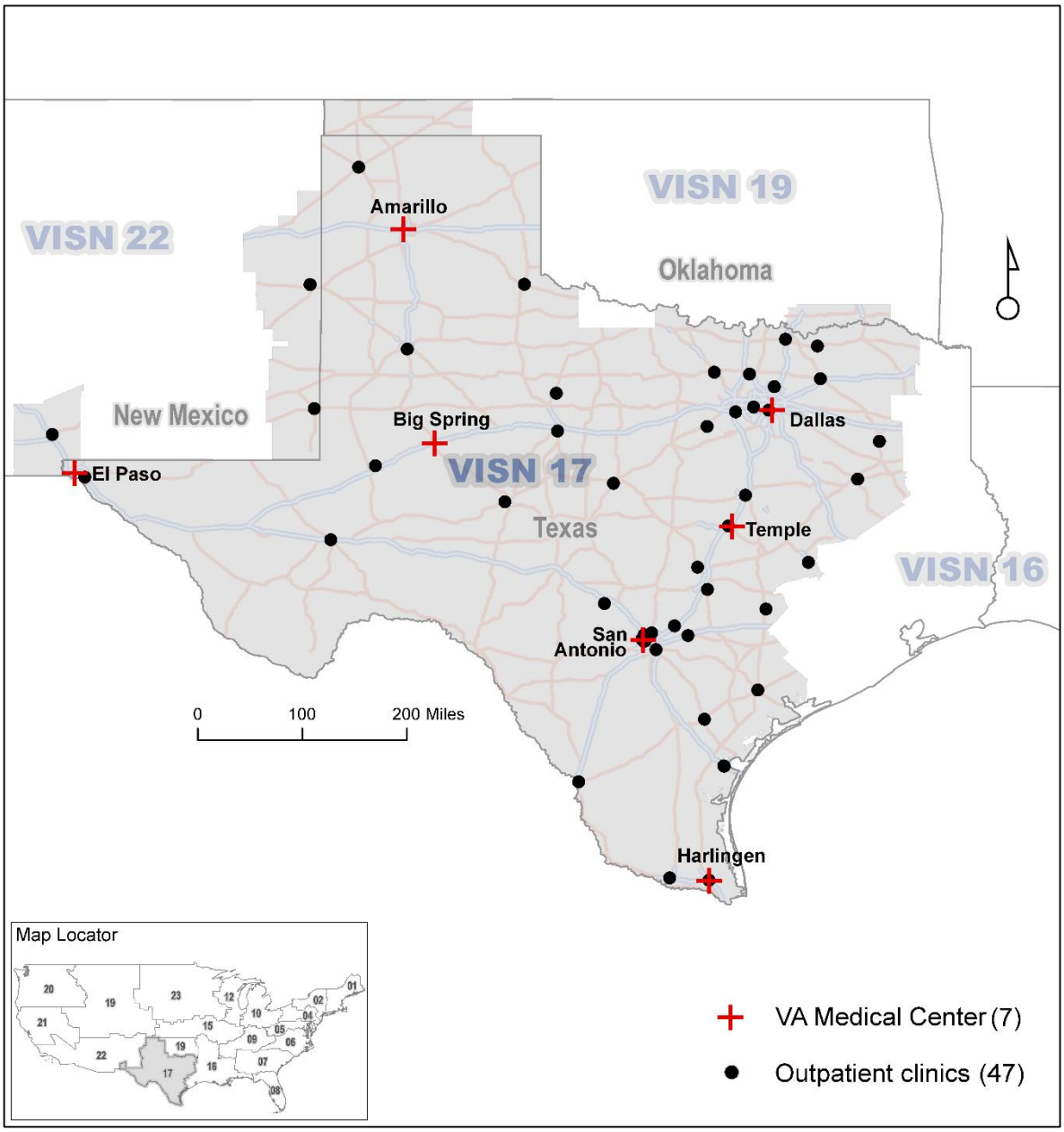

Figure 1. *Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network, Arlington, Texas (Source: OIG)*

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
CMO	chief medical officer
EOC	environment of care
FPPE	focused professional practice evaluation
FY	fiscal year
HCS	health care system
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QMO	quality management officer
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
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 leadership performance and oversight by the Veterans Integrated Service Network (VISN) 17: VA Heart of Texas Health Care Network. The inspection covers key clinical and administrative processes associated with promoting quality care.

CHIP reviews 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 OIG selects and evaluates specific areas of focus on a rotating basis 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).

The OIG conducted this unannounced visit during the week of May 6, 2019, while concurrent inspections of the following VISN 17 facilities were also performed:

- El Paso VA Health Care System (HCS), TX
- VA Texas Valley Coastal Bend Health Care System, Harlingen, TX
- West Texas VA Health Care System, Big Spring, TX

The OIG conducted interviews and reviewed clinical and administrative processes related to the areas of focus that affect patient care outcomes. The findings presented in this report are a snapshot of VISN and facility performance within the identified focus areas at the time of the OIG visit. The findings in this report may help the VISN 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

The VISN leadership team consisted of the network director, deputy network director, chief medical officer (CMO), quality management officer (QMO), and human resources officer. Organizational communication and accountability were managed through a committee reporting structure, with the VISN's Executive Leadership Council having oversight for groups such as the

Organizational Health; Quality, Safety, and Value; Healthcare Delivery; and Healthcare Operations Committees.

The VISN leadership team had worked together for two years, with the network director being the newest member and assigned in April 2017. The CMO, deputy network director, and QMO were assigned in October 2000, September 2004, and July 2007, respectively.

In the review of selected employee satisfaction survey results regarding VISN leaders, the OIG noted that opportunities appear to exist for the CMO to improve employee satisfaction, model servant leadership, improve attitudes toward the workplace, and reduce employee moral distress at work. For selected patient experience survey results, the OIG noted VISN 17 patients appear generally less satisfied than Veterans Health Administration (VHA) patients nationally.

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 and differences between the top and bottom performers" within VHA.[1] Although leadership team members were knowledgeable about selected SAIL and SAIL community living center data, they should continue to take and support facility actions to improve care provided throughout the VISN. The OIG's evaluation of VISN access metrics and clinician vacancies did not identify any significant organizational risks.

The OIG noted findings in all four clinical areas reviewed and issued seven recommendations that are attributable to the network director, CMO, and QMO. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with the establishment of a standing VISN committee with responsibility for key quality, safety, and value functions and facilities' completion of at least 75 percent of all required inpatient stay reviews. The OIG did not identify trends in noncompliance during VISN 17 facility CHIP reviews. However, the OIG identified deficiencies with the committee meeting at least quarterly; analysis and review of aggregated quality, safety, and value data; and the collection, analysis, and action in response to VISN peer review data that warranted recommendations for improvement.

[1] 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=2146. (The website was accessed on September 11, 2018, but is not accessible by the public.)

Medical Staff Privileging

During concurrent VISN 17 facility CHIP site visits, the OIG identified trends in noncompliance related to focused and ongoing professional practice evaluations that warranted recommendations for improvement.[2]

Environment of Care

The OIG found evidence of a written policy that establishes and maintains a comprehensive environment of care program, an established VISN emergency management committee, and inventory management programs assessed through a quality control review once per fiscal year. The OIG did not identify trends in noncompliance during VISN 17 facility CHIP reviews. However, the OIG identified a concern with the VISN safety and network emergency management committee that warranted a recommendation for improvement.

Medication Management

The OIG did not identify trends in noncompliance during VISN 17 facility CHIP reviews. However, the OIG identified a deficiency with the QMO's review of VISN facilities' controlled substances inspection quarterly trend reports that warranted a recommendation for improvement.

Summary

In the review of key care processes, the OIG issued seven recommendations that are attributable to the network director, CMO, and QMO. The number of recommendations should not be used as a gauge for the overall quality provided within this VISN. The intent is for VISN leaders to use these recommendations as a road map to help improve operations and clinical care throughout the network of assigned facilities. 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.

[2] 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."

Comments

The Veterans Integrated Service Network director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendix G, page 51, and the responses within the body of the report for the full text of the network directors' comments.) The OIG considers recommendations 1, 2, 3, and 7 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) review is to evaluate leadership performance and oversight by Veterans Integrated Service Network (VISN) 17: VA Heart of Texas Health Care Network. This focused evaluation is accomplished by examining a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The OIG reports findings to VISN leaders so that informed decisions can be made to improve 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.[3] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[4]

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

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)

[3] 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.)

[4] 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.)

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 documents and administrative and performance measure data and discussed processes and validated findings with VISN leadership and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from May 21, 2018, through May 10, 2019, the last day of the unannounced week-long site visit.[5] The review was performed during concurrent inspections of VISN 17's El Paso VA Health Care System (HCS), VA Texas Valley Coastal Bend HCS, and West Texas VA HCS. While on site, the OIG referred issues and concerns beyond the scope of the CHIP review to our 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 VISN completes corrective actions. The network director's comments submitted in response to the report recommendations appear within each topic area.

The OIG conducted the 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.

[5] The range represents the time period from the last CHIP review to the completion of the unannounced week-long VISN CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the ability to provide care in all the selected clinical and administrative areas of focus.[6] To assess the VISN's risks, the OIG considered the following indicators:

1. Executive leadership stability and engagement
2. Employee satisfaction
3. Patient experience
4. Access to care
5. Clinician vacancies
6. Oversight inspections
7. VHA performance data

Additionally, the OIG assessed VISN 17 efforts to reduce the rates of suicides, a leading cause of death in the United States.[7]

Executive Leadership Position Stability and Engagement

A VISN consists of a geographic area which encompasses a population of veteran beneficiaries. The VISN is defined based on VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VA medical centers, clinics, and other sites; contractual arrangements with private providers; sharing agreements; and other government providers. The VISN is designed to be the basic budgetary and planning unit of the veterans health care system.[8]

According to data from the VA National Center for Veterans Analysis and Statistics, VISN 17 had a veteran population greater than 1.5 million within its borders at the end of fiscal year (FY)

[6] 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.)

[7] The Centers for Disease Control and Prevention, *CDC Vitalsigns*™. June 2018. https://www.cdc.gov/vitalsigns/suicide/index.html (The website was accessed on July 12, 2019.)

[8] Detailed explanation of VISNs provided by Carolyn Clancy, MD, Executive in Charge, Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, May 22, 2018.

2016. VISN 17 leaders are currently responsible for the oversight of seven medical centers and 47 outpatient clinics.

To do this, VISN 17 has a leadership team consisting of the network director, deputy network director, chief medical officer (CMO), quality management officer (QMO), and human resources officer (HRO). The CMO is responsible for overseeing facility-level patient care programs. Figure 3 illustrates the VISN's reported organizational structure.

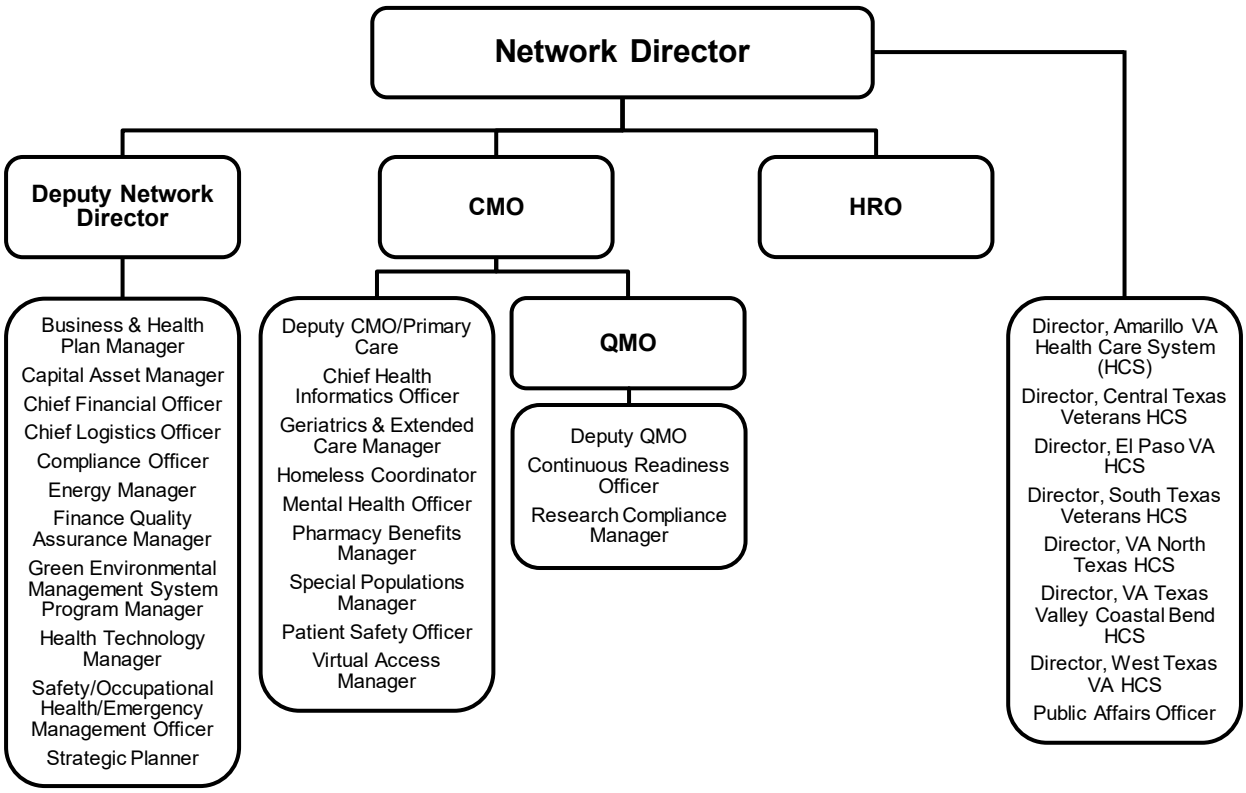

Figure 3. VISN 17 Organizational Chart[9]
Source: VA Heart of Texas Health Care Network (received May 7, 2019)

While the current VISN leadership team has worked together for two years, the deputy network director, CMO, and QMO have served together since 2007. The network director was assigned to the VISN in April 2017. See Table 1.

[9] The Network Director is responsible for the directors at the Amarillo VA HCS, Central Texas Veterans HCS, El Paso VA HCS, South Texas Veterans HCS, VA North Texas HCS, VA Texas Valley Coastal Bend HCS, and West Texas VA HCS; as well as the Public Affairs Officer.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Network Director	April 1, 2017
Deputy Network Director	September 1, 2004
Chief Medical Officer	October 1, 2000
Quality Management Officer	July 1, 2007

Source: VA Heart of Texas Health Care Network (received May 7, 2019)

To help assess VISN executive leaders' engagement, the OIG interviewed the network director, deputy network director, CMO, and QMO regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about VISN and facility actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL Community Living Center (CLC) measures. These are discussed more fully below.

The leaders are members of the VISN's Executive Leadership Council, which is responsible for processes for enhancing network performance, including:

- Conducting strategic planning
- Developing policies
- Allocating financial resources
- Communicating with stakeholders
- Managing organizational performance

The Executive Leadership Council, for which the network director serves as the chairperson, has oversight of various committees, such as the Organizational Health; Quality, Safety and Value; Healthcare Delivery; and Healthcare Operations Committees. See Figure 4.

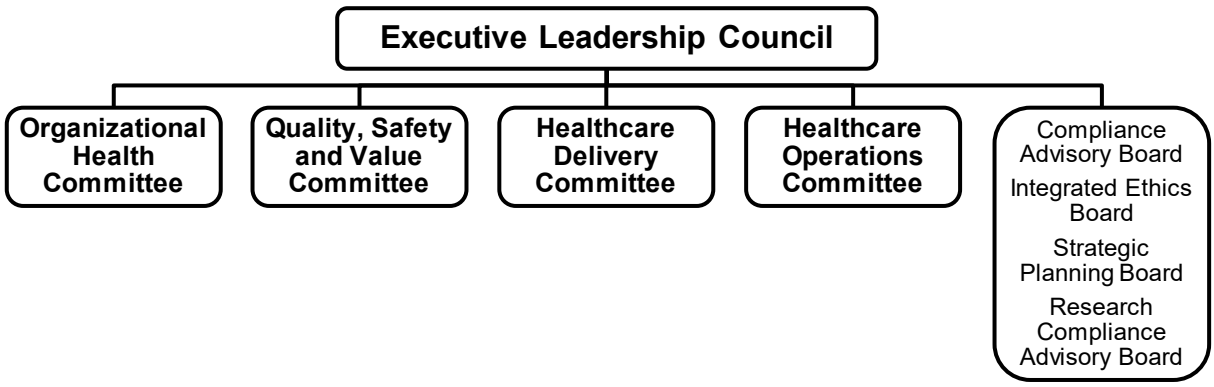

Figure 4. *VISN 17 Committee Reporting Structure*[10]
Source: VA Heart of Texas Health Care Network (received May 7, 2019)

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 at 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 VISN leadership.

To assess employee attitudes toward VISN and 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. Table 2 summarizes employee attitudes as expressed in VHA's All Employee Survey for VHA, the VISN office, and VISN leaders. The VISN office averages for the selected survey questions were similar to or above the VHA averages.[11] The same trend was noted for the network director and deputy network director; however, opportunities appear to exist for the CMO to improve employee satisfaction and model servant leadership.

[10] The Executive Leadership Council directly oversees the Compliance Advisory Board, Integrated Ethics Board, Strategic Planning Board, and Research Compliance Advisory Board.

[11] 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.

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

Questions/ Survey Items	Scoring	VHA Average	VISN 17 Office Average	Network Director Average	Deputy Network Director Average	CMO Average
All Employee Survey: *Servant Leader Index Composite*[12]	0–100 where HIGHER scores are more favorable	71.7	73.0	90.0	77.7	63.0
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	3.4	4.4	3.6	2.9
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.5	3.6	4.6	3.7	3.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.6	4.6	3.7	3.1

Source: VA All Employee Survey (accessed April 5, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The VISN office averages were generally better than the VHA averages. The same trend was noted for the network director and deputy network director. Again, opportunities

[12] According to the 2018 VA All Employee Survey (AES) 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."

appear to exist for the CMO to improve attitudes toward the workplace and to reduce employee moral distress at work.

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

Questions/ Survey Items	Scoring	VHA Average	VISN Office Average	Network Director Average	Deputy Network Director Average	CMO 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	4.1	4.6	4.4	3.9
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	4.0	4.7	3.9	3.5
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	1.7	1.1	1.2	1.7

Source: VA All Employee Survey (accessed April 5, 2019)

Patient Experience

To assess patient attitudes toward VISN and 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 of their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for VISN and facility leaders and compares the results to the overall VHA averages.[13]

VHA also collects SHEP survey data from Inpatient, Patient-Centered Medical Home, and Specialty Care Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes towards VISN and facility leaders (see Table 4). The VISN averages for each of the selected survey questions are below the VHA averages, indicating that VISN 17 patients appear generally less satisfied compared to VHA patients in general. VISN 17 facility scores for the selected questions are presented in Appendix B.

Table 4. Survey Results on Patient Attitudes within VISN 17 (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA Average	VISN 17 Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	62.7
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	81.7
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	69.6

[13] Ratings are based on responses by patients who received care at the facility.

Questions	Scoring	VHA Average	VISN 17 Average
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	71.8

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

VHA also collects Inpatient, Patient-Centered Medical Home, and Specialty Care Survey SHEP data by gender. Over the last decade, the number of women using VA health care has nearly doubled; and it is expected that by 2020 that women veterans will comprise nearly 11 percent of the total veteran population. For this reason, it is important for VHA to provide accessible and inclusive care for women veterans.[14,15]

The OIG reviewed responses to several relevant survey questions that reflect patients' attitudes towards VISN and facility leaders (see Tables 5–7). The VISN averages for female respondents on two of the three selected inpatient survey questions were higher than the scores for their VISN male counterparts as well as the VHA averages for both genders. For the patient-centered medical home and specialty care survey questions, the VISN averages for both male and female respondents were generally lower than the corresponding VHA averages. VISN 17 facility scores for the selected questions are presented in Appendix B and note various opportunities for facility improvement.

[14] Altarum Institute. *Study of Barriers for Women Veterans to VA Health Care Final Report*, April 2015.

[15] The Deborah Sampson Act, Senate Bill 514 was introduced by Senator Jon Testor (D-Mont.) on February 14, 2019, with the goal of eliminating barriers to women veteran's care and to require specific data to be tracked and reported so that VHA will be able to direct and focus resources where they are needed most. https://www.congress.gov/bill/116th-congress/senate-bill/514/text. (The website was accessed on June 12, 2019.)

Table 5. Inpatient Survey Results on Patient Attitudes within VISN 17 by Gender (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA		VISN 17	
		Male Average	Female Average	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	83.6	81.4	81.0	85.0
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	82.7	81.9	80.2	83.2
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	67.4	59.5	63.2	54.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed April 12, 2019)

Table 6. Patient-Centered Medical Home Survey Results on Patient Attitudes within VISN 17 by Gender (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA		VISN 17	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.2	40.3	45.2	27.9
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	58.8	49.8	51.6	46.0
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	70.1	65.7	65.0	59.3

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed April 12, 2019)

Table 7. Specialty Care Survey Results on Patient Attitudes within VISN 17 by Gender (October 1, 2017, through September 30, 2018)

Questions	Scoring	VHA		VISN 17	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	47.6	43.2	46.4	40.8
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	55.2	50.7	51.7	50.6
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	68.7	65.5	65.2	69.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed April 12, 2019)

During the OIG interviews, VISN leaders noted that although they had not specifically analyzed male satisfaction scores against female scores, they did analyze specific women veteran issues raised by patient satisfaction surveys. For example, recent data indicated female veteran dissatisfaction with some services at the VA North Texas HCS, which prompted the creation of a prearranged day-care program for children of women veterans and the establishment of separate domiciliary facilities. VISN efforts to improve satisfaction scores also included establishing a pharmacy notification program that sends a text to patients when prescriptions have been sent in the mail and improving access by increasing staffing of telehealth providers for primary care and women veterans.[16]

To address low patient satisfaction scores, VA North Texas HCS, VISN 17, and VHA assisted HCS leadership to train staff and employ "purposeful rounding" to better assess and meet

[16] The "MedText" program was developed by staff at the George H. O'Brien, Jr. VA Medical Center. "MedText" keeps patients informed of prescription renewals by sending a text to their phone notifying them that a prescription has been mailed. Since April 4, 2019, over 30,000 text messages have been sent.

inpatient needs and satisfaction.[17] Additionally, outpatient satisfaction is being measured with Veteran Signals (V Signals), a survey sent to randomly selected veterans about recent encounters with outpatient services.[18]

Access to Care

Achieving and maintaining an optimal workforce to ensure timely access to the best care and benefits for our nation's veterans is a VA priority. VHA has utilized various measures to determine whether access goals are met for both new and established patients, including wait time statistics based on appointment creation and patient preferred dates.[19] Wait time measures based on "create date" do not rely upon the accuracy of the "preferred date" entered into the scheduling system. These measures are particularly applicable for new primary care patients where the care is not initiated by referral, or consultation, and includes a "clinically indicated date." The disadvantage to "create date" metrics is that wait times do not account for specific patient requests/availability. Wait time measures based on patient preferred dates, however, consider patient preferences but rely upon appointment schedulers accurately recording the patients' wishes into the scheduling software.[20]

VHA has a goal of providing patient care appointments within 30 calendar days of the clinically indicated date, or the patient's preferred date if a clinically indicated date is not provided.[21] When facilities were not able to offer appointments within 30 days of clinically indicated or preferred dates, patients became eligible to receive non-VA (community) care through the VA Choice Program—eligible patients were given the choice to schedule a VA appointment beyond the 30-day access goal or make an appointment with a non-VA community provider.[22] However,

---

[17] *Patient Satisfaction and Patient Safety: Outcomes of Purposeful Rounding,* Topics in Patient Safety, VA National Center for Patient Safety, Vol 11, Issue 4, July/August 2011. Purposeful rounding is a nursing program that employs checking patients at a regular interval (usually one hour) to check on the "3Ps" – Pain, Positioning and Personal needs.

[18] Veterans Signals (V Signals) is a VHA survey sent to veterans who received outpatient services within the previous week. Surveys remain open for two weeks after the invitation is sent. The feedback veterans submit is used to quickly help inform opportunities for service recovery and performance improvement. See https://www.data.va.gov/story/key-indicators-veterans-signals-vha-outpatient-survey. (The website was accessed on June 7, 2019.)

[19] Completed Appointments Cube data definitions, https://bioffice.pa.cdw.va.gov/. (The website was accessed on March 28, 2019, but is not accessible by the public.)

[20] Office of Veterans Access to Care, *Specialty Care Roadmap*, November 27, 2017.

[21] According to VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures,* July 15, 2016 (amended July 12, 2019), the "Clinically Indicated Date (CID) is the date an appointment is deemed clinically appropriate by a VA health care provider. The CID is contained in a provider entered Computerized Patient Record System order indicating a specific return date or interval such as 2, 3, or 6 months. The CID is also contained in a consult request…The preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity."

[22] VHA Directive 1700, *Veterans Choice Program*, October 25, 2016.

with the passage of the VA MISSION Act on June 6, 2018, and subsequent enactment on June 6, 2019, eligibility criteria for obtaining care in the community now include average drive times and appointment wait times:[23]

- Average drive time
  - 30-minute average drive time for primary care, mental health, and noninstitutional extended care services
  - 60-minute average drive time for specialty care
- Appointment wait time
  - 20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA health care provider
  - 28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA health care provider

To assess access to primary and mental health care within VISN 17, the OIG reviewed clinic wait time data for completed new patient appointments in primary care and mental health clinics for the most recently completed quarter. Tables 8 and 9 provide wait time statistics for completed primary care and mental health appointments from January 1, 2019, through March 31, 2019.

[23] VA Office of Public Affairs Media Relations, Fact Sheet: Veteran Community Care – Eligibility, VA MISSION Act of 2018, April 2019.

Table 8. Primary Care Appointment Wait Times[24]
(January 1, 2019, through March 31, 2019)

Facility	Number of New Patient Appointments	Average New Patient Wait from Create Date
VISN 17: VA Heart of Texas Health Care Network	11,159	20.1
Amarillo VA HCS	587	17.7
Central Texas Veterans HCS	1,990	19.6
El Paso VA HCS	931	19.8
South Texas Veterans HCS	2,381	18.3
VA North Texas HCS	3,650	22.2
VA Texas Valley Coastal Bend HCS	1,180	19.2
West Texas VA HCS	440	20.1

Source: VHA Support Service Center (accessed April 17, 2019)

Table 9. Mental Health Appointment Wait Times[25]
(January 1, 2019, through March 31, 2019)

Facility	New Patient Appointments	Average New Patient Wait from Preferred Date
VISN 17: VA Heart of Texas Health Care Network	2,282	11.2
Amarillo VA HCS	112	3.9
Central Texas Veterans HCS	644	12
El Paso VA HCS	240	9.6
South Texas Veterans HCS	571	11.6
VA North Texas HCS	373	14.9
VA Texas Valley Coastal Bend HCS	165	4.6
West Texas VA HCS	177	9.9

Source: VHA Support Service Center (accessed April 17, 2019)

[24] Reported primary care wait times are for appointments designated as clinic stop 323 (Primary Care Medicine), which records visits for comprehensive primary care services.

[25] Reported mental health wait times are for appointments designated as clinic stop 502 (Mental Health Clinic Individual), which records visits for the evaluation, consultation, and/or treatment by staff trained in mental diseases and disorders.

Based upon wait times alone, the MISSION Act may improve access to primary care for patients in VISN 17, where the average wait time for primary care appointments is near or above 20 days. However, the wait times also highlight opportunities for these facilities to improve the timeliness of primary care provided "in house" and thus decrease the potential for fragmented care among those who are referred to community providers.

The Veterans Equitable Resource Allocation (VERA) database is relied upon for resource allocation in VHA. According to the network director, the veteran population in the Dallas area has grown 3 percent over the past year.[26] To address the increased growth, the VISN engaged in market assessment analyses to identify eligible veterans in various health care markets and plan to establish clinics in these markets; opened the Grand Prairie Community Based Outpatient Clinic; funded staff for a telehealth hub; and improved compensation for mental health providers. To further increase access in the greater Dallas area, the VISN is pursuing acquisition of a private hospital that is closing and coordinating these efforts with VHA and interested VA stakeholders.

Clinician Vacancies

Within the healthcare field, there is general acceptance that staff turnover, or instability, and high clinical vacancy rates negatively impact access to care, quality of health care provided, patient safety, and patient and staff satisfaction. Turnover can directly affect staffing levels and reduce staff and organizational performance through the loss of experienced staff.[27]

To assess the extent of clinical vacancies across VISN 17 facilities, the OIG requested and reviewed the number of vacancies by facility, position, service/section, and full-time equivalents (FTE). Table 10 provides the vacancy rates across the VISN for all position types as of May 7, 2019.

Table 10. Reported Vacancy Rates for VISN 17 Facilities (as of May 7, 2019)

Facility	Vacant FTE	Total Onboard FTE	Vacancy Percentage
Amarillo VA HCS	181.8	1210.4	13.1%
Central Texas Veterans HCS	715.8	4279.6	14.3%
El Paso VA HCS	212.6	1073.9	16.5%

[26] The Veterans Equitable Resource Allocation database, known as VERA, pulls data from several VA databases and is combined to develop patient-specific care and cost data, which forms the basis for resource allocation in VHA.

[27] J. Buchanan. Reviewing the Benefits of Health Workforce Stability. *Human Resources for Health*: 2010; 8–29. VHA Research Series: *The Business Case for Work Force Stability* (2002).

Facility	Vacant FTE	Total Onboard FTE	Vacancy Percentage
South Texas Veterans HCS	513.1	4334.2	10.6%
VA North Texas HCS	568.1	5851.4	8.9%
VA Texas Valley Coastal Bend HCS	198.0	955.4	17.2%
West Texas VA HCS	175.0	664.2	20.9%

Source: VA Heart of Texas Health Care Network human resources information specialist (received July 12, 2019)

Upon closer inspection, the OIG found many clinical vacancies across VISN 17 for physicians (~200 FTE) and nurses (>460 FTE). The VISN leadership acknowledged difficulties in recruiting physicians in some geographic areas. However, the VISN is actively utilizing the "3 Rs" (recruitment bonus, relocation allowance, and retention bonus) to recruit and retain providers and using the telehealth hub to provide increased access throughout the VISN.

Given the potential opportunities to improve primary care wait times across VISN 17, the OIG also reviewed the number of primary care physician vacancies at the VA North Texas HCS and West Texas VA HCS where primary care wait times exceeded 20 days (see Table 11). With vacancy rates ranging from 12 to 32 percent, provider staffing did not appear to be a significant contributing factor for primary care wait time challenges in the VA North Texas HCS but appeared to be a contributing factor in the West Texas VA HCS.

Table 11. Estimated Primary Care Provider Vacancy Rates for Selected Facilities (as of May 7, 2019)

Facility	Vacant FTE	Total Provider FTE	Vacancy Percentage
VA North Texas HCS	16	138	12%
West Texas VA HCS	8	17	32%

Source: VA Heart of Texas Health Care Network human resources information specialist (received July 16, 2019)

VISN Efforts to Reduce Veteran Suicides

Suicide is a leading cause of death in the United States, and suicide rates in almost all states increased from 1999 through 2016.[28] Although the unadjusted rate of suicide among veterans decreased from 30.5 to 30.1 per 100,000 veterans from 2015 to 2016, the suicide rate for veterans age 18–34 has risen substantially since 2005. With approximately 20 million veterans in United States, the number of veterans who die by suicide annually is significant.[29] Further, the issue of suicide has garnered recent Congressional and media interest, given the suicides of three veterans at VA facilities in Georgia and Texas within five days of each other in April 2019.

VA has made suicide prevention its top priority with the Office of Mental Health and Suicide Prevention by implementing significant suicide prevention initiatives: expanding the Veterans Crisis Line to three call centers, launching the S.A.V.E. suicide prevention training video,[30] implementing the Mayor's Challenge, and partnering with the departments of Defense and Homeland Security to support veterans during their transition from military to civilian life.[31]

Interviewed leaders were knowledgeable about efforts taken to reduce veteran suicide in VISN 17 and shared information, listed below, that highlighted those efforts:

- Coordinated in-person meetings with facility-level Veterans Service Organizations to explore local options for suicide prevention
- Engaged in Tele Townhall meetings to publicize suicide prevention protocols
- Collaborated with the largest private mental health services provider in North Texas to provide outreach services to at-risk veterans
- Testified before the Texas State Senate Veterans Affairs Committee to assist state efforts in addressing and preventing veteran suicide

VISN leadership opined that resources and funding for VHA suicide prevention efforts were satisfactory; however, leadership also suggested that increased resources for coordination with local outreach programs would help identify and assist at-risk veterans who are not enrolled in the VHA system.

---

[28] The Centers for Disease Control and Prevention. *CDC Vitalsigns™,* June 2018.

[29] Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs, February 5, 2019. https://www.mentalhealth.va.gov/suicide_prevention/. (The website was accessed on April 12, 2019.)

[30] VA Operation S.A.V.E. outlines steps for staff to help veterans: Signs of suicidal thinking, Ask questions, Validate the veteran's experience, Encourage treatment, and Expedite getting help. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4071. (The website was accessed on June 21, 2019.)

[31] Office of Mental Health and Suicide Prevention, *VA National Suicide Data Report 2005-2016,* September 2018.

Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections to gauge how well leaders respond to identified problems. Except for those made in recently published reports, VISN and facility leaders have closed all recommendations for improvement listed in Appendix C.[32]

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.[33]

VA also uses a star-rating system where VISNs and facilities with a "5-star" rating are performing within the top 10 percent and "1-star" VISNs and facilities are performing within the bottom 10 percent. As of June 30, 2018, VISN 17 was rated at "3-star" for overall quality. Table 12 summarizes the SAIL star-ratings for facilities within the VISN.

Table 12. VISN 17 Facility SAIL Star-Ratings for Overall Quality (as of June 30, 2018)

Facility	Star Rating
Amarillo VA HCS	4
Central Texas Veterans HCS	3
El Paso VA HCS	1
South Texas Veterans HCS	3
VA North Texas HCS	2
VA Texas Valley Coastal Bend HCS	2
West Texas VA HCS	1

Source: VHA Support Service Center (accessed April 5, 2019)

[32] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations.

[33] 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.)

Figure 5 illustrates the VISN's quality of care and efficiency metric rankings and performance compared as of December 31, 2018. Of note, Figure 5 uses blue and green data points to indicate high performance (for example, in the areas of call responsiveness, health care (HC) associated infections, and best place to work). Metrics that need improvement are denoted in orange and red (for example, specialty care (SC) survey access, patient-centered medical home (PCMH) care coordination, and rating (of) primary care (PC) provider).[34]

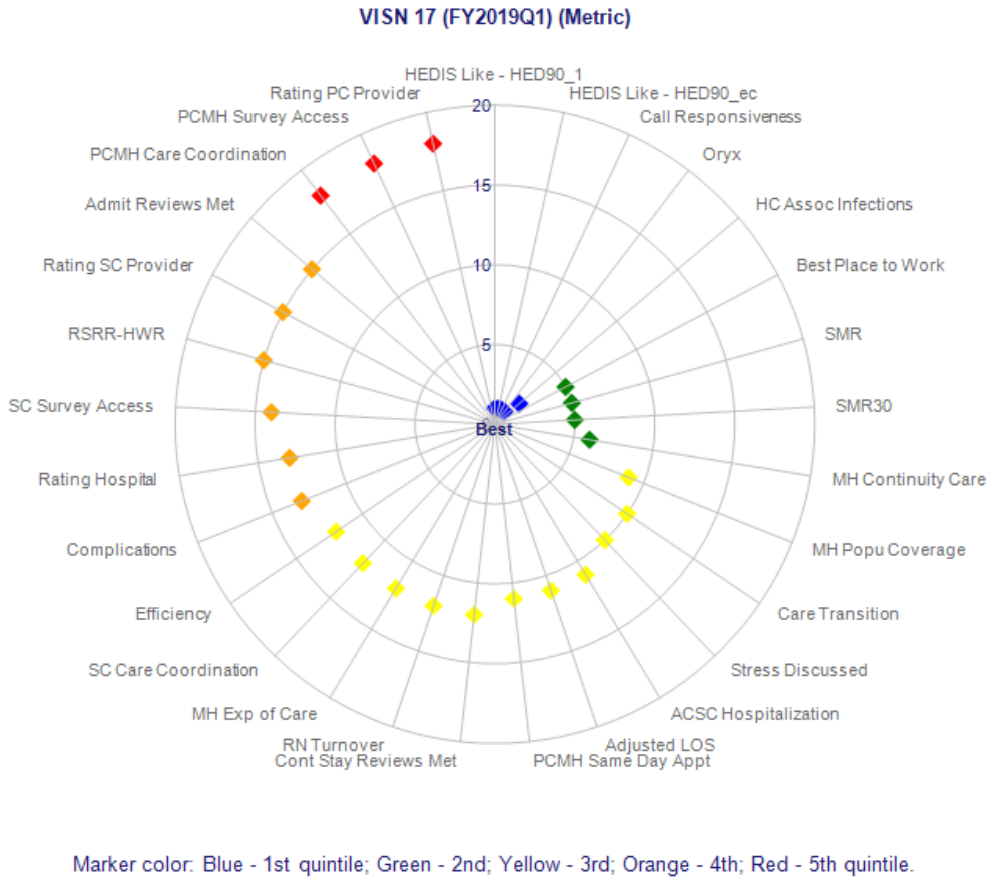

Figure 5. *VISN 17 Quality of Care and Efficiency Metric Rankings (as of December 31, 2018).*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix D.

Much of the 5th quintile SAIL data reflected patient satisfaction concerns that centered on hospital and provider ratings and attitudes about access to care. The VISN has been active in supporting the lower star-rated facility efforts to improve.

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

Permanent leadership assignments over the last year at the El Paso VA HCS have improved employee morale and stability. From first quarter FY 2018 to first quarter FY 2019, primary and specialty care access and wait time scores showed improvement; and scores for ambulatory care sensitive conditions moved from the 5th to 4th quintile, suggesting a meaningful change between time periods.[35] To improve access, telehealth resources have been added, additional space has been obtained from a Department of Defense partner, and the VISN has funded renovations to meet environment of care standards.

Lack of leadership stability has been a factor in the West Texas VA HCS SAIL ratings. Recruiting efforts have resulted in the hiring of a permanent chief of staff and associate director; however, the facility director is scheduled to transfer to another medical center, and efforts are underway to find a permanent replacement.

The SAIL Value Model also includes "SAIL CLC," which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare*.[36] The SAIL CLC provides a single resource to review quality measures and health inspection results. It includes star-ratings for an unannounced survey, staffing, quality, and overall results.[37] Table 13 summarizes the rating results for the facility CLCs within the VISN as of December 31, 2018.

[35] SAIL analyzes ambulatory care sensitive condition (ACSC) hospitalizations due to hypertension and pneumonia, for example, which are preventable if ambulatory care is provided in a timely and effective manner. Effective primary care is associated with fewer ACSC-related hospitalizations and is used as an indicator of access and quality primary care. See https://www.va.gov/QUALITYOFCARE/measure-up/SAIL_definitions.asp. (The website was accessed on June 6, 2019.)

[36] According to Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

[37] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

Table 13. VISN 17 SAIL CLC Star-Ratings
(as of December 31, 2018)

CLC Location	Unannounced Survey Star Rating	Staffing Star Rating	Quality Star Rating	Overall Star Rating
Amarillo, TX	3	5	2	4
Big Spring, TX	4	5	1	4
Bonham, TX	3	5	2	4
Dallas, TX	3	5	2	4
Kerrville, TX	3	5	3	4
San Antonio, TX	4	5	2	5
Temple, TX	5	5	2	5
Waco, TX	4	5	1	4

Source: VHA Support Service Center (accessed April 5, 2019)

The SAIL CLC also includes a radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 6 illustrates the VISN's quality of care and efficiency metric rankings and performance 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 urinary tract infections (UTI)–long stay (LS) and improvement in function–short stay (SS)). Measures that need improvement are denoted in orange and red (for example, moderate-severe pain–LS, catheter in bladder–LS, and new or worse pressure ulcer (PU)–SS)).[38]

[38] For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

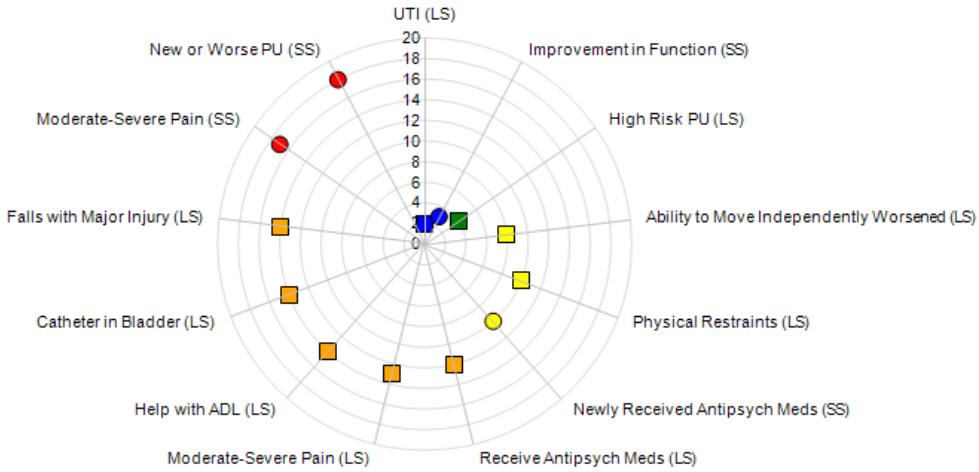

Figure 6. *VISN 17 SAIL CLC Quality Measure Rankings (as of December 31, 2018).*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. For data definitions, see Appendix E.
LS = Long-Stay Measure *SS = Short-Stay Measure*

Although the CMS *Nursing Home Compare* overall star-ratings (Table 13) are positive for all VISN CLCs, the quality star-ratings, with the exception of Kerrville, TX, are "1-star" or "2-star." The CMO acknowledged that the Big Spring and Waco CLCs were rated a "1-star" in quality. The data suggested issues with preventing pressure ulcers and controlling urinary tract infections. The CLCs submitted action plans to the VISN geriatrics and extended care manager that addressed staff education in preventing pressure ulcers and urinary tract infections. Also, VISN leadership reviews pain treatment and pressure ulcer care weekly.

Leadership and Organizational Risks Conclusion

The VISN 17 leadership team is stable with three of four positions permanently filled for over 10 years, and the full team had worked together for over two years. Selected survey scores related to employee satisfaction and attitudes toward the workplace were generally above VHA averages, except for the CMO who appears to have opportunities to improve both employee satisfaction and attitudes toward the workplace. The OIG noted various opportunities for the VISN to support its facilities to improve the patient experience. The leaders appeared to support efforts to improve patient safety, quality care, and other positive outcomes (such as coordinating and supporting plans to improve positive perceptions of VISN facilities through stake holder engagement, for instance, Tele Townhall meetings with staff and veterans). The OIG's evaluation of VISN access metrics and clinician vacancies did not identify any significant organizational risks. The leadership team was knowledgeable within their scope of responsibility about selected SAIL and SAIL CLC metrics but should continue to take actions to support facility actions to improve care provided throughout VISN 17.

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.[39] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[40] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[41]

In determining whether the VISN implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV, the inspection team interviewed VISN managers and reviewed meeting minutes and other relevant documents. Specifically, the OIG evaluated the following VISN-level performance indicators:

- Standing VISN committee with responsibility for key QSV functions
  - Committee met at least quarterly
  - Committee chaired or co-chaired by the VISN director
  - Committee reviewed aggregated QSV data and took necessary actions
- Completion of at least 75 percent of all required inpatient reviews[42]
- Collection, analysis, and action, as appropriate, in response to VISN peer review data[43]

The OIG also interviewed VISN managers and evaluated relevant documents when concurrent VISN 17 facility CHIP reviews identified trends in noncompliance.

Quality, Safety, and Value Conclusion

The OIG found general compliance with the establishment of a standing VISN committee with responsibility for key QSV functions that was chaired by the network director and facilities'

[39] 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 but was rescinded on October 24, 2019.)

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

[41] VHA Directive 1026.

[42] VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (This directive expired on July 31, 2019.)

[43] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

completion of at least 75 percent of all required inpatient reviews. However, the OIG identified deficiencies with the QSV committee meeting at least quarterly to analyze and review aggregated QSV data and peer review summary data that are collected, analyzed, and acted upon as appropriate that warranted recommendations for improvement.

Specifically, VHA requires that VISNs establish a standing committee that meets at least quarterly and analyze and review aggregated QSV data.[44] The OIG found that the QSV committee only met in January, March, and November 2018, and March 2019.[45] The OIG did not find evidence of committee review of aggregated QSV data over the past 12 months. This could potentially result in a lack of follow-up on key items and missed opportunities for improvement. The QMO cited reasons for noncompliance, including the lack of QSV committee delegates authorized to represent an absent member, difficulty coordinating committee members' availability for QSV meetings, and lack of a formal committee reporting structure.

Recommendation 1

1. The network director makes certain that the quality, safety, and value committee meets at least quarterly.[46]

VISN concurred.

Target date for completion: September 2019

VISN response: VISN 17's QSV meeting started meeting regularly in January, 2019 with a standardized agenda and a new calendar of agenda items developed to ensure that all topics were being presented based on Directive requirements. VISN QSV Committee has met 8 out of the past 10 months (Meetings held: January 22; March 8; April 9; May 10; July 8; August 27; September 30; October 28), which has exceeded the quarterly requirements for greater than 6 months. Due to the regularity and consistency of the meetings, VISN 17 requests closure of this recommendation.

Recommendation 2

2. The network director ensures the quality, safety, and value committee analyzes and reviews aggregated quality, safety, and value data.[47]

[44] VHA Directive 1026.

[45] The QMO reported that the March 2018 QSV committee minutes were not transcribed.

[46] The OIG reviewed evidence sufficient to demonstrate that the VISN had completed improvement actions and therefore closed the recommendation before the report's release.

[47] The OIG reviewed evidence sufficient to demonstrate that the VISN had completed improvement actions and therefore closed the recommendation before the report's release.

VISN concurred.

Target date for completion: September 2019

VISN response: VISN 17's QSV meeting started meeting regularly in January, 2019 with a standardized agenda and a new calendar of agenda items developed to ensure that all topics were being presented based on Directive requirements. VISN QSV Committee has met 8 out of the past 10 months (Meetings held: January 22; March 8; April 9; May 10; July 8; August 27; September 30; October 28), which has exceeded the quarterly requirements for greater than 6 months. Due to the regularity and consistency of the meetings, VISN 17 requests closure of this recommendation.

VHA requires VISN peer review summary data to be "collected, analyzed, and acted upon, as appropriate."[48] The OIG did not find evidence that VISN leaders analyzed or took actions on any peer review summary data. This resulted in missed opportunities for network-wide performance improvements. The QMO and quality management specialist reported reviewing and discussing the peer review data but did not document communication to the network director because there was no formal committee reporting structure. However, the QSV committee recognized the opportunity for improvement prior to the OIG visit and implemented a committee reporting structure with the first QSV meeting having occurred in March 2019. The draft QSV reporting schedule, which outlines the frequency that sub-committees, work groups, and teams routinely report to the QSV committee, is pending finalization.

Recommendation 3

3. The network director makes certain that the quality management officer collects, analyzes, and acts upon Veterans Integrated Service Network peer review summary data as appropriate and monitors the quality management officer's compliance.[49]

VISN concurred.

Target date for completion: October 2019

VISN response: Prior to May 2019, Peer Review data at VISN 17 was being shared with facility Risk Managers as well as facility Chiefs of Staff; however the report was not formally captured in minutes. As part of the standing agenda reports through VISN QSV, Peer review data is annually reported in October each year. The Peer review annual data report was presented to the committee on October 28, 2019. Due to the fact that this is an annual report and is scheduled regularly, VISN 17 requests closure of this recommendation.

[48] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.

[49] The OIG reviewed evidence sufficient to demonstrate that the VISN had completed improvement actions and therefore closed the recommendation before the report's release.

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]

VHA also requires network directors to "maintain an appropriate credentialing and privileging process consistent with the VHA policy" and specifically charges VISN chief medical officers (CMOs) with "oversight of the credentialing and privileging process of the facilities within the VISN."[51]

The OIG interviewed VISN managers and evaluated relevant documents when concurrent VISN facility CHIP reviews identified trends in noncompliance.

Medical Staff Privileging Conclusion

The OIG identified trends in noncompliance during CHIP reviews related to focused professional practice evaluations (FPPEs) and ongoing professional practice evaluations (OPPEs) that warranted recommendations for improvement.[52]

Specifically for FPPEs, VHA requires criteria be defined in advance, objective, and accepted by the practitioner.[53] The OIG found that criteria for the LIPs' focused professional practice evaluation process were not defined in advance at the El Paso VA HCS and VA Texas Valley Coastal Bend HCS. This could potentially result in unclear and ill-defined expectations for the medical staff leaders performing the evaluation as well as the providers who are being evaluated. The CMO did not indicate a reason for the noncompliance, but reported noting these trends prior to the OIG visit as part of a mock OIG audit and had implemented a corrective process.

---

[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] 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."

[53] VHA Handbook 1100.19.

Recommendation 4

4. The chief medical officer confirms that facility service chiefs clearly define focused professional practice evaluation criteria in advance with licensed independent practitioners and monitors facility service chiefs' compliance.

VISN concurred.

Target date for completion: May 2020

VISN response: VISN 17 CMO and Deputy QMO have conducted mock surveys at both El Paso and Valley Coastal Bend. El Paso Mock review was conducted by VISN CMO and VISN Deputy QMO on February 5, 2019. During that review VISN identified that El Paso was not notifying the provider of evaluation criteria in advance of the FPPE. A follow up report was provided to the facility on February 5, 2019 and action items were put into place by June, 2019. Since the OIG CHIP review looked retrospectively at these cases, the same items that the VISN identified were also identified and cited by the OIG. Moving forward the site is expected to have completed required items. Valley Coastal Bend Mock surveys were conducted by VISN CMO and VISN Deputy QMO on January 31, 2019. During that review VISN identified that Valley Coastal Bend was not notifying the provider of evaluation criteria in advance of the FPPE. A follow up report was provided to the facility on February 2, 2019, and action items were put into place by March, 2019. Since the OIG CHIP review looked retrospectively at these cases, the same items that VISN identified were also identified and cited by the OIG. Moving forward the site is expected to have completed required items. VISN will receive a monthly report from both El Paso and Valley Coastal Bend to ensure that new providers are being notified of FPPE criteria in advance. VISN will monitor compliance at both sites until 90% compliance is gained and sustained for a period of 6 months. In addition, VISN will monitor actions submitted to OIG CHIP quarterly. Progress of these actions will be tracked through the VISN QSV Committee.

Additionally, VHA requires, at the time of reprivileging, that each service chief establishes criteria for clinical privileges "consistent with the needs of the service and the facility as well as [within] the available resources to provide these services. Clinical privileges must be based on evidence of an individual's current competence."[54] The OIG found that LIPs' ongoing professional practice evaluation criteria were not specific to the service/section at the El Paso VA HCS and VA Texas Valley Coastal Bend HCS. The VISN CMO and quality management specialist believed they were compliant because they proactively conducted random chart reviews at both sites in February 2019 and did not find issues with this performance indicator.

[54] VHA Handbook 1100.19.

Recommendation 5

5. The chief medical officer confirms that facility service chiefs include service-specific criteria in ongoing professional practice evaluations and monitors clinical managers' compliance.

VISN concurred.

Target date for completion: May 2020

VISN response: VISN 17 CMO and Deputy QMO have conducted mock surveys at both El Paso and Valley Coastal Bend. El Paso Mock review was conducted by VISN CMO and VISN Deputy QMO on February 5, 2019. During that review VISN identified that the facility did not conduct privilege specific review during OPPE. A follow up report was provided to the facility on February 8, 2019, and action items were put into place by June, 2019. Since the OIG CHIP review looked retrospectively at these cases, the same items that VISN identified were also identified and cited by the OIG. Moving forward the site is expected to have completed required items. Valley Coastal Bend Mock surveys were conducted by VISN CMO and VISN Deputy QMO on January 31, 2019. During that review, the VISN identified that the facility did not conduct privilege specific review during OPPE. A follow up report was provided to the facility on February 1, 2019, and action items were put into place by March, 2019. Since the OIG CHIP review looked retrospectively at these cases, the same items that the VISN identified were also identified and cited by the OIG. VISN will receive a monthly report from both El Paso and Valley Coastal Bend to ensure that OPPE includes service-specific criteria. VISN will monitor compliance at both sites until 90% compliance is gained and sustained for a period of 6 months. In addition, VISN will monitor actions submitted to OIG CHIP quarterly. Progress of these actions will be tracked through the VISN QSV Committee.

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.[55] To support these efforts, VHA requires VISNs to enact written policy that establishes and maintains a comprehensive environment of care program at the VISN level.[56]

The OIG interviewed VISN managers and evaluated meeting minutes and other relevant documents. Specifically, the OIG evaluated the following VISN-level performance indicators:[57]

- Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level
- Establishment of a VISN Emergency Management Committee (EMC)[58]
  - VISN EMC met at least quarterly
  - VISN EMC documented an annual review of the VISN Emergency Operation Plan (EOP) within the previous 12 months
  - VISN EMC documented an annual review of the VISN Continuity of Operation Plan within the previous 12 months
  - VISN EMC documented an annual review of the VISN Hazard Vulnerability Analysis within the previous 12 months
  - VISN EMC conducted, documented, and sent an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to VISN leadership for review and approval
- Assessment of inventory management programs through a quality control review once per FY[59]

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

[56] VHA Directive 1608.

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

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

[59] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.

Environment of Care Conclusion

The OIG found evidence of a written policy that establishes and maintains a comprehensive environment of care program, an established VISN emergency management committee, and inventory management programs assessed through a quality control review once per fiscal year. The OIG did not identify any environment of care patterns or trends during CHIP reviews within the VISN. However, the OIG identified a deficiency with the VISN safety and network emergency management committee that warranted a recommendation for improvement.

VHA requires VISNs to establish an EMC that meets at least quarterly; documents an "annual review of the VISN [Office] EOP [Emergency Operations Plan], Continuity of Operations Plan (COOP), and Hazards Vulnerability Analysis (HVA);" and conducts, documents, and sends an annual review of the "collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement…to VISN leadership for review and approval."[60] The OIG found that the VISN safety and network emergency management committee conducted and documented an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement but did not send the annual review to VISN leadership for approval. This insufficient communication to the network director could prevent oversight of emergency management readiness. The safety and occupational health manager and QMO cited that the annual review was not reported through the QSV committee as there was no formal committee reporting structure.

Recommendation 6

6. The network director makes certain that the Veterans Integrated Service Network safety and network emergency management committee sends an annual review of the collective Veterans Integrated Service Network-wide strengths, weaknesses, priorities, and requirements for improvement to leadership for review and approval and monitors the committee's compliance.

[60] VHA Directive 0320.01.

VISN concurred.

Target date for completion: January 2020

VISN response: The VISN 17 Network Safety and Emergency Management Committee provides quarterly reports to the Quality, Safety and Value Committee and Network Director that addresses compliance of each Healthcare System's Environment of Care and Emergency Management programs. Quarterly reports have been presented at the January, March, May and August meetings. The next annual report is scheduled to be presented during the first meeting of FY2020.

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.[61] 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.[62]

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. VHA also requires VISN and facility quality managers to review controlled substances inspection quarterly trend reports to ensure adherence with program requirements and that facilities take corrective actions when needed.[63]

The OIG interviewed VISN managers and evaluated relevant documents to assess whether the QMO reviewed facility quarterly trend reports and when concurrent facility-level CHIP reviews identified trends in noncompliance.

Medication Management Conclusion

The OIG identified noncompliance with the VISN review of facility quarterly trend reports that warranted a recommendation for improvement.

Specifically, VHA requires VISN QMOs to review facilities' controlled substances inspection quarterly trend reports and ensure facilities take corrective actions, when needed.[64] The OIG found that the QMO did not review facilities' controlled substances inspection quarterly trend reports within the previous 12 months. As a result, the VISN QMO missed opportunities to ensure facilities' compliance with the controlled substances inspection program. The QMO and quality management specialist reported that they reviewed the quarterly trend reports but the VHA directive did not require documentation. They also stated the lack of a formal committee reporting structure and insufficient staffing as additional reasons for noncompliance. The quality management specialist acknowledged that there are some opportunities for improvement and that the controlled substances inspection review was noted in the March 2019 minutes.

---

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

[62] 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.

[63] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.

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

Recommendation 7

7. The quality management officer reviews Veterans Integrated Service Network facilities' controlled substances inspection quarterly trend reports.[65]

VISN concurred.

Target date for completion: October 2019

VISN response: VISN 17's QSV meeting started meeting regularly in January 2019 with a standardized agenda and a new calendar of agenda items that include quarterly dashboard of controlled substance reports from all facilities. As stated in the report, VISN 17 began presenting this data in March 2019, prior to OIG's arrival at the VISN. This report included an annual report (4 consecutive rolling quarters of data). As of October 2019, the VISN Deputy QMO has presented controlled substance data in the form of a dashboard with rolling 4 quarters in March, July, and October at the VISN QSV committee. Due to the regularity and consistency of these reports, the VISN has had a greater than 6 month sustainment period and VISN 17 requests closure of this recommendation.

[65] The OIG reviewed evidence sufficient to demonstrate that the VISN had completed improvement actions and therefore closed the recommendation before the report's release.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Findings

The intent is for VISN 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 • Access to care • Clinician vacancies • VISN efforts to reduce veteran suicides • Oversight inspections • VHA performance data	Seven OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the network director, CMO, and QMO. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Quality, Safety, and Value	• Standing VISN committee with responsibility for key QSV functions
	• Completion of at least 75 percent of all required inpatient reviews
	• Collection, analysis, and action, as appropriate, in response to VISN peer review data
	• Facility-level CHIP indicators:
	  ○ Protected peer reviews
	  ○ UM reviews
	  ○ Patient safety
	  ○ Resuscitation episode review
		• VISN QSV committee reviews aggregated QSV data.
		• VISN QMO collects, analyzes, and acts upon VISN peer review summary data as appropriate.
			• VISN QSV committee meets at least quarterly.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	• Facility-level CHIP indicators: ○ Privileging ○ FPPEs ○ OPPEs ○ FPPEs for cause ○ Reporting of privileging actions to National Practitioner Data Bank	• Facility service chiefs ensure LIPs OPPEs include service-specific criteria.	• Facility service chiefs ensure that criteria for LIPs FPPEs are defined in advance.
Environment of Care	• Establishment of VISN policy that maintains a comprehensive environment of care program at the VISN level • Establishment of a VISN Emergency Management Committee • Assessment of inventory management programs through a quality control review once per FY • Facility-level CHIP indicators: ○ Parent facility ○ Community based outpatient clinic ○ Locked inpatient mental health unit ○ Emergency management	• None	• VISN Emergency Management Committee sends an annual review of the collective VISN-wide strengths, weaknesses, priorities, and requirements for improvement to leadership for review and approval.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Medication Management: Controlled Substances Inspections	• VISN quality management officer review of facility quarterly trend reports
	• Facility-level CHIP indicators:
	  ○ Controlled substances coordinator reports
	  ○ Pharmacy operations
	  ○ Controlled substances inspector requirements
	  ○ Controlled substances area inspections
	  ○ Pharmacy inspections
	  ○ Facility review of override reports
		• VISN QMO reviews facilities' controlled substances inspection quarterly trend reports.	• None

Appendix B: VISN 17 Profile

The table below provides general background information for VISN 17.

Table B.1. Profile for VISN 17
(October 1, 2015, through September 30, 2018)

Profile Element	VISN Data FY 2016[66]	VISN Data FY 2017[67]	VISN Data FY 2018[68]
Total medical care budget in dollars	$3,365,266,336	$3,367,865,507	$3,810,668,790
Number of:			
• Unique patients	407,301	414,571	424,774
• Outpatient visits	4,919,178	5,042,707	5,271,728
• Unique employees[69]	11,869	14,749	15,120
Type and number of operating beds:			
• Community living center	795	795	774
• Domiciliary	666	640	630
• Hospital	707	699	695
• Residential rehabilitation	33	33	28
Average daily census:			
• Community living center	568	557	567
• Domiciliary	495	523	445
• Hospital	454	441	410
• Residential rehabilitation	21	16	17

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

[66] October 1, 2015, through September 30, 2016.
[67] October 1, 2016, through September 30, 2017.
[68] October 1, 2017, through September 30, 2018.
[69] Unique employees involved in direct medical care (cost center 8200).

Appendix C: Survey Results

Table C.1. Survey Results on Patient Attitudes within VISN 17 (October 1, 2017, through September 30, 2018)

Questions	Scoring	Facility	Average Score
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family*?	The response average is the percent of "Definitely Yes" responses.	VHA	66.9
		VISN 17	62.7
		Amarillo	66.8
		Central Texas	68.7
		El Paso[70]	n/a
		South Texas	66.5
		North Texas	55.6
		Texas Valley Coastal Bend[71]	n/a
		West Texas[72]	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.	VHA	84.2
		VISN 17	81.7
		Amarillo	85.9
		Central Texas	83.0
		El Paso	n/a
		South Texas	83.0
		North Texas	79.2
		Texas Valley Coastal Bend	n/a
		West Texas	n/a

[70] The facility does not provide inpatient care; therefore, the survey questions are not applicable (n/a).
[71] The facility does not provide inpatient care; therefore, the survey questions are not applicable (n/a).
[72] The facility does not provide inpatient care; therefore, the survey questions are not applicable (n/a).

Questions	Scoring	Facility	Average Score
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.	VHA	76.3
		VISN 17	69.6
		Amarillo	81.8
		Central Texas	66.5
		El Paso	69.9
		South Texas	72.9
		North Texas	67.7
		Texas Valley Coastal Bend	73.9
		West Texas	68.9
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.	VHA	76.5
		VISN 17	71.8
		Amarillo	78.5
		Central Texas	72.7
		El Paso	66.7
		South Texas	74.2
		North Texas	68.4
		Texas Valley Coastal Bend	77.2
		West Texas	73.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)
n/a = Not applicable

Table C.2. Inpatient Survey Results by Gender within VISN 17 (October 1, 2017, through September 30, 2018)

Questions	Scoring	Facility	Male Average	Female Average
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**83.6**	**81.4**
		VISN 17	81.0	85.0
		Amarillo	82.0	95.0
		Central Texas	81.5	86.0
		El Paso	n/a	n/a
		South Texas	82.0	87.2
		North Texas	79.8	81.1
		Texas Valley Coastal Bend	n/a	n/a
		West Texas	n/a	n/a
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**82.7**	**81.9**
		VISN 17	80.2	83.2
		Amarillo	86.5	69.6
		Central Texas	84.1	83.4
		El Paso	n/a	n/a
		South Texas	84.1	93.0
		North Texas	74.0	77.0
		Texas Valley Coastal Bend	n/a	n/a
		West Texas	n/a	n/a
Would you recommend this hospital to your friends and family?	The reporting measure is calculated as the percentage of responses in the top category (Definitely yes).	**VHA**	**67.4**	**59.5**
		VISN 17	63.2	54.8
		Amarillo	67.5	56.0
		Central Texas	69.2	62.5
		El Paso	n/a	n/a
		South Texas	67.1	57.0
		North Texas	56.1	47.5
		Texas Valley Coastal Bend	n/a	n/a
		West Texas	n/a	n/a

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed April 12, 2019)
n/a = Not applicable

Table C.3. Patient-Centered Medical Home Survey Results by Gender within VISN 17 (October 1, 2017, through September 30, 2018)

Questions	Scoring	Facility	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**50.2**	**40.3**
		VISN 17	45.2	27.9
		Amarillo	57.2	57.4
		Central Texas	44.0	19.9
		El Paso	46.6	45.9
		South Texas	46.7	27.4
		North Texas	43.1	33.4
		Texas Valley Coastal Bend	48.2	13.2
		West Texas	41.7	37.9
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**58.8**	**49.8**
		VISN 17	51.6	46.0
		Amarillo	56.6	63.2
		Central Texas	50.4	41.4
		El Paso	53.1	45.6
		South Texas	56.8	47.8
		North Texas	48.1	47.8
		Texas Valley Coastal Bend	54.5	43.5
		West Texas	51.8	60.9
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	**VHA**	**70.1**	**65.7**
		VISN 17	65.0	59.3
		Amarillo	74.4	77.4
		Central Texas	60.3	50.6
		El Paso	68.6	47.4
		South Texas	70.6	66.4
		North Texas	63.9	67.4
		Texas Valley Coastal Bend	67.8	55.3
		West Texas	53.7	38.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed April 12, 2019)

Table C.4. Specialty Care Survey Results by Gender within VISN 17 (October 1, 2017, through September 30, 2018)

Questions	Scoring	Facility	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**47.6**	**43.2**
		VISN 17	46.4	40.8
		Amarillo	46.3	15.1
		Central Texas	47.9	36.9
		El Paso	48.0	26.7
		South Texas	47.3	42.8
		North Texas	44.2	50.4
		Texas Valley Coastal Bend[73]	47.7	—
		West Texas[74]	43.6	—
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	**VHA**	**55.2**	**50.7**
		VISN 17	51.7	50.6
		Amarillo	53.0	42.8
		Central Texas	52.4	49.8
		El Paso	47.9	41.4
		South Texas	56.5	59.9
		North Texas	48.0	44.6
		Texas Valley Coastal Bend	55.6	56.4
		West Texas	54.9	75.1
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	**VHA**	**68.7**	**65.5**
		VISN 17	65.2	69.1
		Amarillo	69.2	82.3
		Central Texas	64.9	63.5
		El Paso	59.5	59.5
		South Texas	70.8	70.2
		North Texas	61.6	72.1
		Texas Valley Coastal Bend	72.2	86.2
		West Texas	63.6	85.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed on April 12, 2019)

[73] Although the facility provides specialty care, data not available for the limited number of female respondents.

[74] Although the facility provides specialty care, data not available for the limited number of female respondents.

Appendix D: Office of Inspector General Inspections

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas, Report No. 16-00118-321, June 14, 2016	March 2016	0	10	n/a	0
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Amarillo VA Health Care System, Amarillo, Texas, Report No. 16-00028-337, June 23, 2016	March 2016	0	10	n/a	0
Healthcare Inspection – Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA Health Care System, Amarillo, Texas, Report No. 14-03822-289, July 6, 2017	August 2014 January 2015 March 2016	0	2	n/a	0
Healthcare Inspection – Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA Health Care System, Amarillo, Texas, Report No. 14-03822-359, September 7, 2017	August 2014 January 2015 March 2016	0	2	n/a	0
Comprehensive Healthcare Inspection Program Review of the West Texas VA Health Care System, Big Spring, Texas, Report No. 17-01742-90, February 5, 2018	June 2017	0	11	n/a	1
Comprehensive Healthcare Inspection Program Review of the VA North Texas Health Care System, Dallas, Report No. 17-05404-149, Texas, March 29, 2018	December 2017	0	6	n/a	2

Report Title	Date of Visit	Number of VISN Recommendations	Number of Facility Recommendations	Number of Open VISN Recommendations	Number of Open Facility Recommendations
Clinical Assessment Program Review of the VA El Paso Health Care System, El Paso, Texas, Report No. 16-00578-291, July 17, 2017	February 2017	0	10	n/a	0
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	0	14	n/a	0
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Texas Valley Coastal Bend Health Care System, Texas, Harlingen, Report No. 15-05149-88, January 28, 2016	November 2015	0	2	n/a	0
Comprehensive Healthcare Inspection Program Review of the South Texas Veterans Health Care System, San Antonio, Texas, Report No. 17-01852-59, January 8, 2018	May 2017	0	3	n/a	0
Comprehensive Healthcare Inspection Program Review of the Central Texas Veterans Health Care System Temple, Texas, Report No. 18-01137-15, November 29, 2018	May 2017	0	18	n/a	18

Sources: (Inspection/survey results verified with the Quality Management Specialist on May 7, 2019.
n/a = Not applicable

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[75]

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

[75] 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 F: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions[76]

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

[76] *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410. (The website was accessed on March 6, 2019, but is not accessible by the public.)

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 22, 2019

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

Subj: Comprehensive Healthcare Inspection of the VA Heart of Texas Health Care Network, Arlington, TX

To: Director, Office of Healthcare Inspections (54CH04)

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

Thank you for the opportunity to provide a response for the VISN 17 OIG CHIP Draft Report.

I have reviewed and concur with the 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.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Randall Snow, JD, Team Leader Tishanna McCutchen, DNP, MSPH
Other Contributors	Shirley Carlile, BA Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Yoonhee Kim, PharmD Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, MSN, RN

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 17: VA Heart of Texas Health Care Network

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
New Mexico – Martin Heinrich, Tom Udall
Oklahoma – James Inhofe, James Lankford
Texas – John Cornyn, Ted Cruz
U.S. House of Representatives:
New Mexico – Debra Haaland, Ben Ray Lujan, Xochitl Torres Small
Oklahoma – Frank Lucas, Markwayne Mullin
Texas – Colin Allred, Jodey Arrington, Brian Babin, Kevin Brady, Michael C. Burgess, John R. Carter, Joaquin Castro, Michael Cloud, Mike Conaway, Dan Crenshaw, Henry Cuellar, Lloyd Doggett, Veronica Escobar, Lizzie Fletcher, Bill Flores, Sylvia Garcia, Louis Gohmert, Vicente Gonzalez, Lance Gooden, Kay Granger, Al Green, Will Hurd, Sheila Jackson Lee, Eddie Bernice Johnson, Kenny E. Marchant, Mike McCaul, Pete Olson, John Ratcliffe, Chip Roy, Van Taylor, Mac Thornberry, Marc Veasey, Filemon Vela, Randy Weber, Roger Williams, Ron Wright

OIG reports are available at www.va.gov/oig.