Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00305-123

Combined Assessment Program Review of the Southern Arizona VA Health Care System Tucson, Arizona

April 14, 2014

Washington, DC 20420

Glossary

CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Southern Arizona VA Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 6, 2014.

Review Results: The review covered seven activities. The facility's reported accomplishment was outpatient phlebotomy wait times.

Recommendations: We made recommendations in all seven of the following activities:

Quality Management: Perform continuing stay reviews on at least 75 percent of patients in acute beds. Ensure that the Surgical Work Group meets monthly and that all surgical deaths are reviewed.

Environment of Care: Require that patient care areas in the community living center are clean and that damaged walls in the community living center are repaired and maintained. Ensure all workers who occasionally access the acute mental health unit receive the required training.

Medication Management: Conduct and document patient learning assessments. Ensure clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers.

Coordination of Care: Identify post-discharge needs, and include them in discharge planning. Ensure patients receive ordered aftercare services within the ordered/expected timeframe.

Nurse Staffing: Monitor the staffing methodology that was implemented in May 2013. Ensure members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management: Perform and document a patient skin inspection and risk scale at discharge. Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Revise the prevention plans if risk levels change for patients at risk for or with pressure ulcers. Ensure all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. Ensure designated employees receive training on how to administer the pressure ulcer risk scale and how to conduct a complete skin assessment.

Community Living Center Resident Independence and Dignity: Document weekly summaries of restorative nursing services in residents' electronic health records.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–27, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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

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

- QM

- EOC

- Medication Management

- Coordination of Care

- Nurse Staffing

- Pressure Ulcer Prevention and Management

- CLC Resident Independence and Dignity

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

The review covered facility operations for FY 2013 and FY 2014 through January 6, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona,* Report No. 10-02124-232, August 25, 2010).

During this review, we presented crime awareness briefings for 299 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 298 responded. We shared summarized results with facility managers.

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

Reported Accomplishment

Outpatient Phlebotomy Wait Times

Over the past 5 years, the average number of veterans served daily by the outpatient phlebotomy team at the facility has almost doubled. This increase gradually caused longer waiting times. In July 2012, wait times often exceeded an hour. As a result, veteran satisfaction began to decline significantly.

The outpatient phlebotomy team implemented a new process with a coordinator and reorganization of the work area, eliminating the two-step waiting process. The coordinator sets the pace between blood draws while the phlebotomist sets the pace for time spent with the veteran.

As a result of the new process, veteran wait times were reduced from an average of 73 minutes in FY 2012 to less than 10 minutes in FY 2013. As the wait times for veterans dropped, satisfaction scores soared. Small changes continue to be made by phlebotomy staff and laboratory management to sustain and improve patient care in the outpatient phlebotomy area. This will continue to be an ongoing process for the near future. VISN 18 recognized this as a best practice.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Twelve months of continuing stay data reviewed: • For all 12 months, less than 75 percent of acute inpatients were reviewed.
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted: • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only met two times over the past 6 months. Several surgical deaths occurred from April through September 2013: • There was no evidence that any of the deaths were reviewed.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of patients in acute beds.

2. We recommended that the Surgical Work Group meet monthly.

3. We recommended that processes be strengthened to ensure that all surgical deaths are reviewed.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in radiology and acute MH were met.[2]

We inspected seven inpatient areas (2S, 3E, 3N, the CLC, the intensive care unit, the step-down unit, and the acute MH unit), the emergency department, two outpatient clinics, and the radiology department. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training records (10 radiology employees, 10 acute MH unit employees, 5 Multidisciplinary Safety Inspection Team members, and 5 employees who occasionally access the acute MH unit). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	In the CLC: • Ten patient bathroom floors were in need of deep cleaning. • Five patient rooms had walls behind the beds that were in need of repair. Two had large holes, and three were damaged. • Hallway floors in the locked dementia area were in need of cleaning.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

NM	Areas Reviewed for Radiology	Findings
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	

NM	Areas Reviewed for Acute MH (continued)	Findings
X	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist and VA's National Center for Patient Safety study of suicide on psychiatric units.	• Two employees who occasionally accessed the acute MH unit had not completed training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.
	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

4. We recommended that processes be strengthened to ensure that patient care areas in the CLC are clean and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that walls in the CLC are repaired and maintained.

6. We recommended that processes be strengthened to ensure that all workers who occasionally access the acute MH receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	• Four patients (12 percent) did not have documented learning assessments.
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For 3 of the 18 patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers.
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

7. We recommended that processes be strengthened to ensure that patient learning assessments are conducted and documented and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 29 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	• Three of the applicable eight EHRs did not contain documentation that clinicians addressed post-discharge needs related to prosthetics.
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
X	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	• Nine of 27 patients who had services ordered did not receive them within the ordered/expected timeframe.
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

9. We recommended that processes be strengthened to ensure that clinicians identify post-discharge needs and include them in discharge planning.

10. We recommended that processes be strengthened to ensure that patients receive ordered aftercare services within the ordered/expected timeframe.

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and 39 training files, and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• Initial implementation was not completed until May 20, 2013.
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
X	Members of the expert panels completed the required training.	• Twenty of the 21 members of the unit-based expert panels had not completed the required training. • Fifteen of the 18 members of the facility expert panel had not completed the required training.
NA	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

11. We recommended that nursing managers monitor the staffing methodology that was implemented in May 2013.

12. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 26 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 6 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected four patient rooms. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Five of the applicable 18 EHRs did not contain documentation that a skin inspection and risk scale were performed at discharge.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 16 of the 26 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Three of the applicable 23 EHRs did not contain consistent documentation that staff revised the prevention plan if the risk level changed.
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
X	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	• Two of the applicable six EHRs did not contain evidence of wound care follow-up plans at discharge or of patient receipt of dressing supplies prior to discharge.

NM	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 6 of the applicable 20 patients at risk for/with a pressure ulcer, EHRs did not contain evidence that education was provided.
X	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	Facility pressure ulcer staff education requirements reviewed: • Three employee training records did not contain evidence of how to administer the pressure ulcer risk scale and how to conduct a complete skin assessment.
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

13. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale at discharge and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that acute care staff revise the prevention plans if risk levels change for patients at risk for or with pressure ulcers and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

17. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

18. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the pressure ulcer risk scale and how to conduct a complete skin assessment and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 10 EHRs of residents (9 residents receiving restorative nursing services and 1 resident not receiving restorative nursing services but a candidate for services). We also observed 1 resident during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on Rehabilitative/Restorative/Supportive Nursing Care Program reviewed: • Two of the applicable nine residents did not have a weekly restorative nursing summary documented in the EHR.

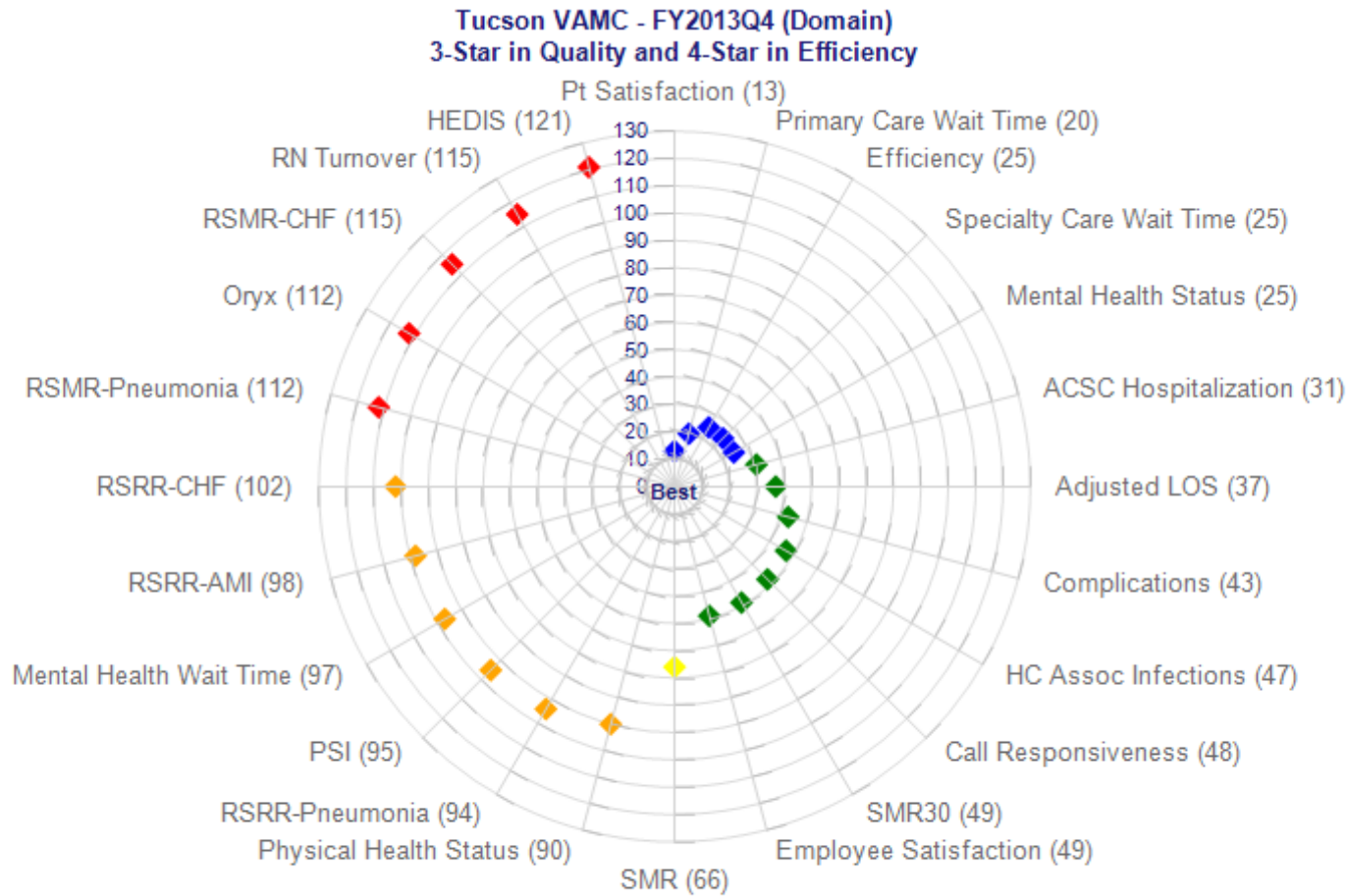| NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

19. We recommended that processes be strengthened to ensure that staff document weekly summaries of restorative nursing services in residents' EHRs.

Facility Profile (Tucson/678) FY 2014 through February 2014[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$429.1
Number of:	
• **Unique Patients**	41,772
• **Outpatient Visits**	274,715
• **Unique Employees**[b]	1,880
Type and Number of Operating Beds (December 2013):	
• **Hospital**	171
• **CLC**	90
• **MH**	16
Average Daily Census (January 2014):	
• **Hospital**	147
• **CLC**	61
• **MH**	13
Number of CBOCs	7
Location(s)/Station Number(s)	Sierra Vista/678GA Yuma/678GB Casa Grande/678GC Safford/678GD Green Valley/678GE Northwest CBOC/678GF Southeast CBOC/678GG
VISN Number	18

[a] All data is for FY 2014 through February 2014 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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

Tucson VAMC - FY2013Q4 (Domain)
3-Star in Quality and 4-Star in Efficiency

Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

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[c] Metric definitions follow the graphs.

Scatter Chart

FY2013Q4 Change in Quintiles from FY2011

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

**Department of
Veterans Affairs**   **Memorandum**

Date: March 25, 2014

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

Subject: **CAP Review of the Southern Arizona VA Health Care
System, Tucson, AZ**

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

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

1. I concur with the attached facility responses and action plans detailed
   in this report of the Combined Assessment Program Review of the
   Southern Arizona VA Health Care System (SAVAHCS).

2. If you have additional questions or concerns, please contact
   Robert Baum, VISN 18 Executive Officer to the Network Director, at
   (480) 397-2777.

Susan P. Bowers

Facility Director Comments

**Department of
Veterans Affairs**   **Memorandum**

Date: March 24, 2014

From: Director, Southern Arizona VA Health Care System (678/00)

Subject: **CAP Review of the Southern Arizona VA Health Care System, Tucson, AZ**

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

1. I concur with the findings and recommendations of the Office of inspector General Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson Arizona.

2. Attached are the facility actions taken as a result of these findings. If you have questions or require additional information, please contact Margaret C. Lumm, Clinical Director, Performance Management at (520) 629-1882.

Jonathan H. Gardner, MPA, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that continued stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: Completed

Facility response: The SAVAHCS experienced turnover of two positions in our Utilization Management staff which impacted our ability to conduct some clinical stay reviews from January 2013 to August 2013. The Case Coordination Department filled the vacant RN Reviewer positions in August and December 2013 which facilitated enhanced monitoring of utilization management reviews. The percentage of completed continued stay reviews, according to the VSSC Monthly Utilization Management Profile, exceeded the benchmark of 75% since August 2013, and the Case Coordination Department continues to conduct continued stay reviews for each hospital day.

Month	Result
August 2013	76.6%
September 2013	92.6%
October 2013	81.4%
November 2013	82.1%
December 2013	89.2%
January 2014	91.3%
February 2014	82.9%

Recommendation 2. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: Completed

Facility response: The facility established a Surgical Work Group which has met monthly since October 2013 and will continue to meet monthly in the future.

Recommendation 3. We recommended that processes be strengthened to ensure that all surgical deaths are reviewed.

Concur

Target date for completion: January 2014

Facility response: In January 2014, surgical death reviews were added as a standing agenda item to the Surgical Work Group.

Recommendation 4. We recommended that processes be strengthened to ensure that patient care areas in the CLC are clean and that compliance be monitored.

Concur

Target date for completion: Completed March 2014

Facility response: All of the patient bathroom floors in the occupied units of the CLC were deep cleaned and a sealer applied. The hallway floors in the locked dementia area were scrubbed and are now being scrubbed weekly until new flooring is installed. Staff working in the area were provided refresher training emphasizing how to identify and report damages. To enhance compliance with monitoring of Environment of Care (EOC), a Standard Operating Procedure was developed outlining housekeeping supervisory staff responsibilities.

Recommendation 5. We recommended that processes be strengthened to ensure that walls in the CLC are repaired and maintained.

Concur

Target date for completion: Completed March 2014

Facility response: The walls in the CLC were repaired and repainted. New wall protection was installed to accommodate the height of the new beds. Staff working in the area were provided refresher training emphasizing how to identify and report damage.

Recommendation 6. We recommended that processes be strengthened to ensure that all workers who occasionally access the acute MH receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Concur

Target date for completion: May 2014

Facility response: The facility is enhancing the process for completing and recording training in the Talent Management System on how to identify and correct environmental hazards, proper use of the MH EOC Checklist and VA's National Center for Patient Safety study of suicide on psychiatric units. Compliance with these training and education requirements is monitored by the Clinical Director, Education, Training and Development.

Recommendation 7. We recommended that processes be strengthened to ensure that patient learning assessments are conducted and documented and that compliance be monitored.

Concur

Target date for completion: Completed March 2014

Facility response: The facility added a new category under the education tab in the Electronic Health Record (EHR) called "New Medication Education." This category allows for any new medications to be included in the patient's education plan. Under this tab, a "Readiness to Learn" and a "Response to Teaching" section were included to ensure learning assessments are conducted and documented. Education Assessment compliance is monitored by the Patient Education Committee.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: Completed March 2014

Facility response: The facility added a new category under the education tab (addressed in recommendation #7) called "New Medication Education." A free text box was added to the education assessment note for the clinician to address the patient's learning barriers and the accommodations made to address those barriers. Education Assessment compliance is monitored by the Patient Education Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that clinicians identify post-discharge needs and include them in discharge planning.

Concur

Target date for completion: Completed March 2014

Facility response: The provider discharge order set in the EHR was revised to address all post discharge needs, including prosthetics, and is integrated into the discharge planning process. The Clinical Director, Care Coordination Department monitors documentation of post discharge needs and inclusion in the discharge planning process.

Recommendation 10. We recommended that processes be strengthened to ensure that patients receive ordered aftercare services within the ordered/expected timeframe.

Concur

Target date for completion: Completed March 2014

Facility response: The facility developed a RN Case Coordination Note in the EHR which identifies required aftercare service needs. The Clinical Director, Care Coordination Department monitors timeliness of orders/supplies/consults for aftercare services.

Recommendation 11. We recommended that nursing managers monitor the staffing methodology that was implemented in May 2013.

Concur

Target date for completion: Completed March 2014

Facility response: The nursing staffing methodology is monitored through a weekly Clinical Nurse Manager meeting. Nursing leadership review and discuss nursing staffing issues and barriers to include nursing hours per patient day (NHPPD). The Associate Chief Nurse verifies compliance with the NHPPD staffing methodology on a monthly basis and reports results to the Nursing Executive Board.

Recommendation 12. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: Completed March 2014

Facility response: All unit and expert panel members (42/42) completed the training for the staffing plan reassessment that is projected to take place in May 2014.

Recommendation 13. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale at discharge and that compliance be monitored.

Concur

Target date for completion: April 2014

Facility response: The facility is coordinating with the EHR vendor, DSS, INC, to revise the discharge note to include a mandatory field on patient skin assessment and the Braden risk scale. Nursing staff conduct monthly audits to ensure compliance with the

documentation. Audit results are reported to the Wound Care Committee which reports to the Quality Committee.

Recommendation 14. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: Completed March 2014

Facility response: A Pressure Ulcer chart audit guide was developed and presented to all Nurse Managers who conduct monthly audits of the EHR to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers review. Nursing staff conduct monthly audits to ensure compliance with the documentation. Audit results are reported to the Wound Care Committee which reports to the Quality Committee.

Recommendation 15. We recommended that processes be strengthened to ensure that acute care staff revise the prevention plans if risk levels change for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: Completed March 2014

Facility response: Nursing staff conduct monthly EHR audits of acute care patients to ensure there is consistent documentation of a revised prevention plan if the risk level changes. Audit results are reported to the Wound Care Committee which reports to the Quality Committee.

Recommendation 16. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

Concur

Target date for completion: Completed March 2014

Facility response: The Discharge Order set in the EHR was revised to include pressure ulcer wound care issues; training; wound supplies; follow-up appointment; and appropriate consults. Nursing staff conduct monthly audits to ensure compliance with the documentation. Audit results are reported to the Wound Care Committee which reports to the Quality Committee.

Recommendation 17. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: Completed March 2014

Facility response: To ensure patients at risk for and with pressure ulcers are educated, RNs review and discuss pressure ulcer education with the patient and/or caregiver. Once patient/caregiver understanding is acknowledged, both the RN and patient/caregiver sign the discharge order as evidence of understanding, and a copy is provided to the patient/caregiver. Nursing staff conduct monthly EHR audits to ensure compliance with the documentation. Audit results are reported to the Wound Care Committee which reports to the Quality Committee.

Recommendation 18. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the pressure ulcer risk scale and how to conduct a complete skin assessment and that compliance be monitored.

Concur

Target date for completion: Completed March 2014

Facility response: The Talent Management System annual training module was revised to include information on how to administer the Braden pressure ulcer risk scale and how to conduct a complete skin assessment. Compliance with the training and education requirements is monitored by the Clinical Director, Education, Training and Development.

Recommendation 19. We recommended that processes be strengthened to ensure that staff document weekly summaries of restorative nursing services in residents' EHRs.

Concur

Target date for completion: Completed February 2014

Facility response: The local facility policy was revised to ensure staff document weekly summaries of restorative nursing services in the residents' EHR. The restorative nursing summaries are documented in the EHR by the Unit RN/Restorative Coordinator assignee. The weekly summaries include documentation of individualized goals, ongoing functional performance and restorative recommendations.

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Endnotes

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